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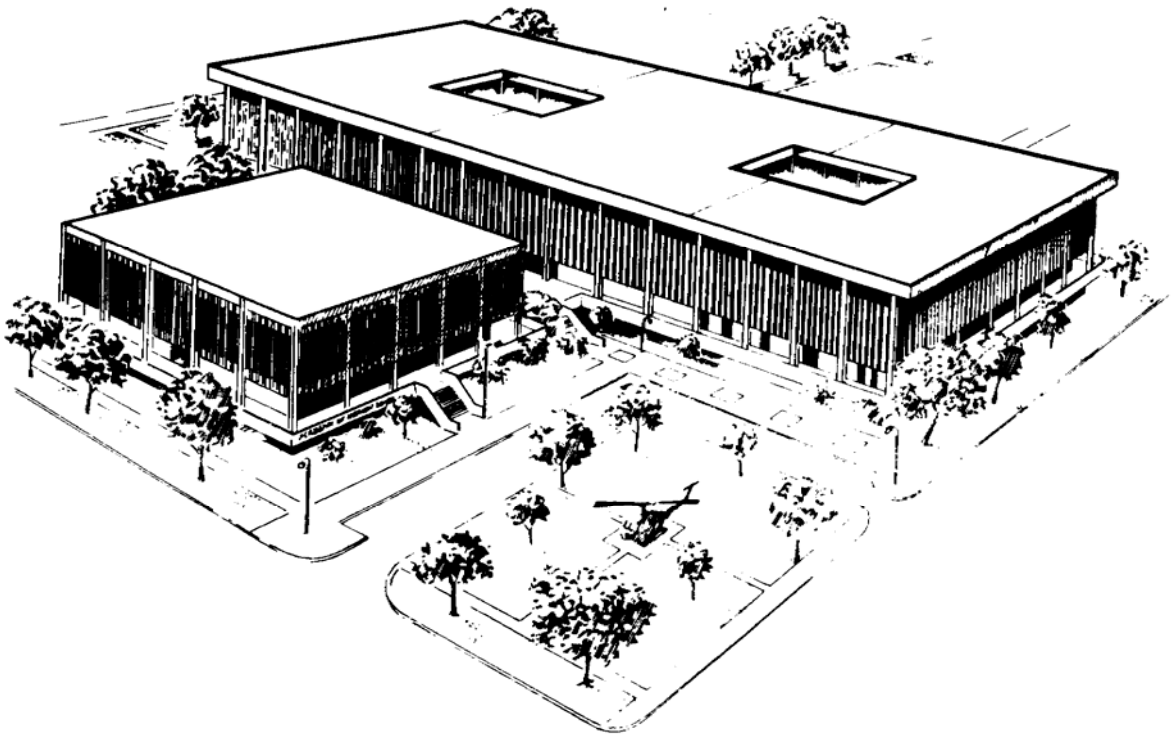
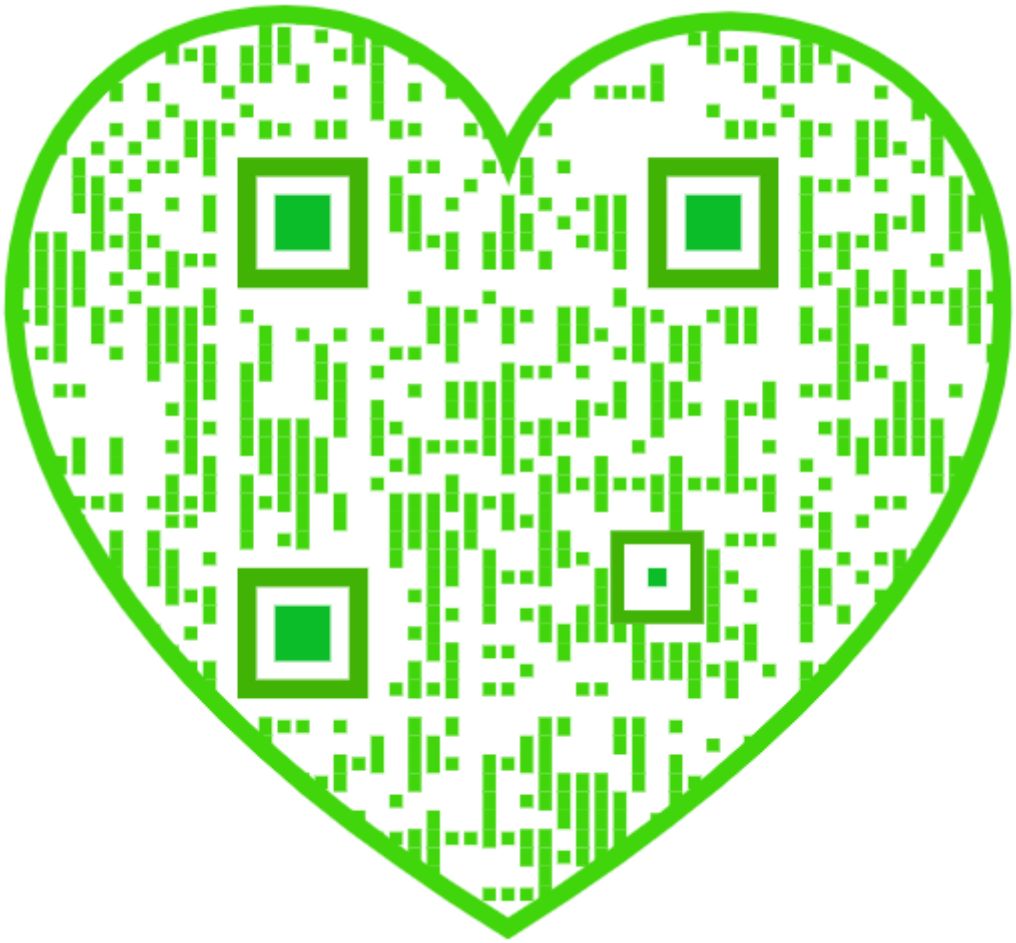


HEALTH CARE ETHICS I

SUBCOURSE MD0066 EDITION 200



DEVELOPMENT

This subcourse is approved for resident and correspondence course instruction. It reflects the current thought of the Academy of Health Sciences and conforms to printed Department of the Army doctrine as closely as currently possible. Development and progress render such doctrine continuously subject to change.

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ADMINISTRATION

Students who desire credit hours for this correspondence subcourse must meet eligibility requirements and must enroll in the subcourse. Application for enrollment should be made at the Internet website: http://www.atrrs.army.mil. You can access the course catalog in the upper right corner. Enter School Code 555 for medical correspondence courses. Copy down the course number and title. To apply for enrollment, return to the main ATRRS screen and scroll down the right side for ATRRS Channels. Click on SELF DEVELOPMENT to open the application and then follow the on screen instructions.

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CLARIFICATION OF TERMINOLOGY

When used in this publication, words such as "he," "him," "his," and "men" 'are intended to include both the masculine and feminine genders, unless specifically stated otherwise or when obvious in context.

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CORRESPONDENCE COURSE OF

THE U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL

SUBCOURSE MDO066

HEALTH CARE ETHICS I

INTRODUCTION

As a practicing health care provider, it is not enough to be technically competent, although it is, admittedly, a critical component of your job. You must balance technical skill (technology) with correct professional demeanor (ethical or right behavior) and sensitivity to the patient's needs (caring). Health care ethics, which is covered in two subcourses (Health Care Ethics I and II), is a philosophical consideration of what is morally right and wrong in the health care setting.

By considering the ethical and legal issues relevant to your role as a health care provider in this subcourse and its sequel (Health Care Ethics II), you will develop a working knowledge of what is appropriate behavior for you as a health provider with regard to both colleagues and patients.

While technical skills give you the baseline competency that you need, a knowledge of ethical and legal issues in health care enables you to make more informed health care decisions with better understanding of the basis for such actions. With conviction in your own actions, you will not only *feel* more confident, but you will *project* confidence to your patients, an essential element in health care provider-patient relationships.

Finally, knowledge of legal considerations related to health care will spare you from unwittingly committing acts that could have legal repercussions (a lawsuit) for the hospital or physician you serve and adverse consequences to your career.

Subcourse Components:

The subcourse instructional material consists of the following:

Lesson 1, Ethics in Health Care
Lesson 2, The Sources and Applications of Ethics
Lesson 3, Legal Considerations
Lesson 4, The Legal Ramifications of Your Every Health Care Move
Lesson 5, Legal Doctrines That Affect Health Care
Appendix A, Code of Ethics for X-Ray Technologists
Appendix B, A Model of a Patient’s Bill of Rights
Appendix C, Glossary of Terms

Here are some suggestions that may be helpful to you in completing this subcourse:

--Read and study each lesson carefully.

--Complete the subcourse lesson by lesson. After completing each lesson, work the exercises at the end of the lesson, marking your answers in this booklet.

--After completing each set of lesson exercises, compare your answers with those on the solution sheet that follows the exercises. If you have answered an exercise incorrectly, check the reference cited after the answer on the solution sheet to determine why your response was not the correct one.

Credit Awarded:

To receive credit hours, you must be officially enrolled and complete an examination furnished by the Nonresident Instruction Branch at Fort Sam Houston, Texas. Upon successful completion of the examination for this subcourse, you will be awarded 12 credit hours.

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A listing of correspondence courses and subcourses available through the Nonresident Instruction Section is found in Chapter 4 of DA Pamphlet 350-59, Army Correspondence Course Program Catalog. The DA PAM is available at the following website: http://www.usapa.army.mil/pdffiles/p350-59.pdf.

LESSON ASSIGNMENT

LESSON 1	Ethics in Health Care.
LESSON ASSIGNMENT	Paragraphs 1-1 through 1-10
LESSON OBJECTIVES	After completing this lesson, you should be able to:

1-1. Define ethics, clinical ethics, biomedical ethics, values, beliefs, and attitudes.

1-2. Identify key features of the American Society of Radiological Technologists (ASRTs) code of ethics.

1-3. Identify key features of the patient's bill of rights.

1-4. Identify the complementary roles of the professional code of ethics and the patient's bill of rights.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 1

Section I. THE NATURE OF ETHICS

1-1. WHY ETHICS?

a. **Introduction**. Most of what your study as a radiographer (or any other health care provider) is concrete, black and white. That is because the skills of an x-ray technologist are based on science. There is, after all, a correct way to position a patient for a chest x-ray, a proper way to insert the intravenous polygram (IVP) injection. But besides the technical aspects of your job (the technology), there is another dimension to health care, more related to the art than the science of healing, that is not so black and white. That other dimension is based on caring and the values of health care. For example, what is the correct way to handle patients when positioning them and project both professionalism and compassion? (Professionalism is not just technically competent, but responsible/serious, in control, and caring.) Are there some instances, for example, when routine handling/ touching could be mistaken for fondling? According to ethics teacher T. Roger Taylor, ethics teaches you "How to do the right thing when no one is looking."[1]

(1) The case of the pornographic poses, cited below, is not hypothetical. It occurred in a military hospital. Refer to the code of ethics adopted by the American Registry of Radiologic Technologists and the American Society of Radiologic Technologists (Appendix A) to determine which tenets of the code were violated. You will see that the x-ray technologist violated principle four of the code by placing the patient in the unseemly positions ("utilizes equipment and accessories consistent with the purposes for which it has been designed."). However, he did adhere to principle seven by not exposing the patient to unnecessary radiation ("limiting the radiation exposure to the patient…"). The radiographer suffered reprisals, of course, for violating the professional code of ethics.

THE CASE OF THE PORNOGRAPHIC POSES

An adolescent girl, sent to the x-ray department for an x-ray, was placed in a series of questionable "pornographic" positions by the radiographer. These had nothing to do with the x-ray that had been ordered by the physician. Fortunately, the x-ray technologist did not compound the misdeed by actually taking the additional poses and exposing the young girl to unnecessary radiation.

(2) Ethics is not just an abstract philosophical study of what is right and wrong. It is about applying morally right behavior to daily life. According to MAJ Michael Frisina, Assistant Professor at West Point," Ethics is about applying right behavior to daily life: it happens at the bedside, in the foxhole, and in the checkout line when you get too much change, and at income tax time when considering deductions."[2]

Figure 1-1. Routine handling or fondling?

b. **Lesson Scope**. This lesson will introduce the topic of ethics. It will examine the way in which culture, geography, and a host of other factors affect your values, beliefs, and attitudes. It will look at the professional code of ethics for x-ray technologists and the patient's bill of rights.

c. **Technology, Caring, and Values**. Any clinical transaction between patient and health care provider involves technology, caring, and values.[3] The mix of these three elements will vary according to the clinical situation. This subcourse looks primarily at values. Because, utilimately, it is the values of the individual and the professional that will influence the quality of the clinical encounter. Our basic ideas about what is right and wrong are determined by our values.

value: a goal or an ideal upon which we base decisions affecting our lives.

d. **Values in an Age of Litigation**. Values take on added importance in an age when lawsuits for incompetence and malpractice are more and more frequent. There was a time when health care professionals were considered ethical by the very nature of their station and duty. Now the ethical (and technical) appropriateness of your health care actions can more easily have legal consequences. In the civilian world, radiographers can be named in lawsuits (along with other health care providers and the hospital itself) if their actions contribute to injuries suffered by a patient. It is, generally, the malpractice insurance of the responsible party (physician, nurse, and/or hospital) that ends up paying if damages are awarded by the court. There is, however, a trend toward increased direct responsibility for the x-ray technologist. In New York State, for example, radiographers are now required to carry malpractice insurance.

e. **Gonzales Act**. The legal situation for military health providers is slightly different than that of their civilian counterparts. The Gonzales Act (10 USC 1089-1976) protects military health care professionals performing their duties in a Federal medical treatment facility (MTF) in the Continental United States (CONUS) from being sued directly. The exclusive remedy for damages from negligent acts of military health care providers (acting within the scope of duty or employment) is against the United States (US). Government. This means that the US Government is named in the suit and the individual health provider does not suffer individual pecuniary liability.

(1) However, military health providers working overseas can be sued; in which case, the Department of Justice defends them and/or provides suitable insurance. So, even military radiographers may be named in a lawsuit, in some settings.

(2) Health care providers must be cognizant of the fact that their health care decisions may have legal repercussions, which can result a range of adverse actions. Even if a provider is not named in a suit and is not required to pay damages, providers can be subject to administrative sanctions, depending on the nature of the misaction. The US Government can, for example, issue a report to the state licensing board recommending removal of a license. Sanctions may include: adverse comments on an officer evaluation report (OER), a Noncommissioned Officer Evaluation Report (NCOER), a military occupational specialty (MOS) reclassification (enlisted), or a report to the accrediting or licensing agency (with possible loss of license). So, health care actions can have administrative and/or legal implications for the health care provider, the rest of the health care team, the hospital, and/or the US Government.

f. **The Importance of Values in Health Care**.

(1) Ultimately, what you do as a health care provider reflects your basic ideas of right and wrong, your personal and professional values. We tend to think that the technology component (the sophistication of the machines and technical expertise of the health care providers) plays the greatest role in health care. (Interestingly

enough, this attitude, itself, is a reflection of an American value that places almost unlimited faith in the power of technology to overcome obstacles, including disease and death.) In fact, caring and values account for more than we think when it comes to good health care.

(2) Consider the comments of Dr. K. L. White, Retired Deputy Director for Health Sciences at The Rockefeller Foundation, in the preface to Lynn Payer's book, Medicine and Culture: "Although things are much better than they were a generation ago, it is still the case that only 15 percent of all contemporary clinical interventions are supported by the objective scientific evidence that they do more good than harm. On the other hand, between 40 and 60 percent of all therapeutic benefits can be attributed to a combination of the placebo and Hawthorne effects, two code words for caring and concern, what most people call 'love'."[5]

> **placebo effect**: a positive therapeutic effect resulting from an inert medication, preparation, or intervention given for its psychological effect, or as a control in an experiment.
>
> **Hawthorne effect**: a temporary positive effect resulting from any change in environment or conditions.

1-2. ETHICS IN YOUR DAY-TO-DAY WORK

a. **Radiographers and Diagnosis**. You have just taken an x-ray of a patient's lungs. He seems visibly anxious and asks you if there are any suspicious spots on the x-ray. You can see that the lungs look clean. You feel for him, and would like to say there's no cause for alarm. It would also feel good (enhance your sense of self-importance) to be the bearer of good news. Do you tell him the results on the spot?

b. **Self-Interest vs Moral Imperative**. How do you balance personal compassion (a desire to satisfy the patient's need to know) with the moral (professional) imperative to leave the diagnosis to the physician? Do you go with your personal feelings when wearing your professional hat? As a professional, you are bound to put your personal feelings aside and follow the moral imperative, the "ought to" that means leave the diagnosis to the physician. (See Appendix A, principle six of the code of ethics.)

c. **Giving Precedence to the Moral Imperative**. In the above example, self-interest (*the patient's* need to know now, and *your* personal desire to comply) is in conflict with the higher moral imperative (to leave the diagnosis to the physician). The choice is quite clear. You must choose in favor of the moral imperative. When there is conflict between self-interest and moral imperative, the moral imperative should win out. Many ethical choices in life are easily resolved, like this one. We generally live our lives making the morally right choices (or consciously selling out, that is, making the morally

wrong choice because it's easier or more convenient). But some of the ethical choices faced by health care providers are not so easily resolved, as we shall see in the next segment.

1-3. ETHICS, A PHILOSOPHIC STUDY OF IDEAL BEHAVIOR

a. **Treating All Patients the Same**. When personal beliefs, attitudes, and values are at cross-purposes with the code of ethics, it becomes hard to live up to ethical principles, which are ideal standards of behavior. For example, principle three of the code of ethics asks radiographers to "deliver patient care unrestricted by the concerns of personal attributes or the nature of the disease and without discrimination…" (See Appendix A, Code of Ethics.)

b. **The Socially Undesirable or Nuisance Patient.** What happens when the health care professional is confronted with a dirty, smelly alcoholic who repeatedly uses a hospital stay as a way of catching his or her second wind before the next drunken binge? Is the alcoholic likely to be the recipient of the same level of care and compassion as any other patient? Personal beliefs, attitudes, and values about cleanliness, alcoholism, and being a responsible citizen may put the health care provider in conflict with the code of ethics.

c. **Care of the Acquired Immunodeficiency Syndrome Patient**. What about the acquired immunodeficiency syndrome (AIDS) patient? How does the health care provider balance the sometimes legitimate (sometimes irrational) concern for his or her own health with the moral requirement to provider care, compassion, and contact comfort to a dying patient? Consider the provider who refuses to care for AIDS patients, or the one who keeps his or her distance (avoiding close physical contact, eye contact, or a comforting word or gesture). When health care providers keep their distance, are they acting out of self-interest (putting their own well-being before that of the patient)? Is a concern for one's own safety an equally valid moral imperative (a legitimate concern for the sanctity of all life, one's own included)?

(1) Refusal to provide care. The AIDS discrimination hot lines receive frequent reports from individuals with the disease who have been refused treatment by doctors and dentists. Do doctors have this right? One recent poll of 54,000 physicians found that 50 percent believed they did and 15 percent said they would actually refuse to provide care.[6] What do you think? Is the answer as clear-cut for you as it is for the doctors who say, "no" or the American Medical Association (AMA) that says, "yes?" Is it a tough choice, but a choice, nonetheless, in which treating the patient is the higher moral imperative? Or is it a moral dilemma in which equally important moral imperatives stand in conflict with each other?

(2) The needle stick case.

(a) Dr. Veronica Prego (perhaps by now decreased) is a 32-year-old doctor who contracted AIDS from an inadvertent stick from a discarded needle that was

contaminated with blood from a patient infected with the human immuniodiciency virus (HIV). She had been direct by her supervising physician, Dr. Joyce Fogel, to gather up some medical debris containing the needle. She settled her lawsuit against New York City hospitals for $1.35 million.[12] Said Prego, "This case is about safety for health care workers in the workplace or lack of it as in my case. It's very important to draw the attention of hospitals, so they realize there's a problem here they need to address."[13] This was the first lawsuit in the country in which a health care worker who contacted AIDS on the job sued a hospital for negligence and was awarded damages.

(b) This case and its outcome point up the ethical responsibility of the hospital to institute practical measures to ensure the safety of its health care workers. Can hospitals come up with workable safety measures? (In fact, it is not the hospital's problem alone. More research on materials and methods to protect caregivers is required. Also, doctors need to play an active role in establishing and reviewing safety and efficiency policies.) The ethical responsibility to provide a safe working environment may seem off the topic, but in fact, it shows how two ethical requirements can be at loggerheads. Does the health care provider have the right to refuse care if all the work environment safety issues have not been resolved? The answer to this ethical dilemma is murky, at best.

d. **The Patient's Risk of Contracting Acquired Immunodeficiency Syndrome From Health Care Providers**. The state of New Jersey is recommending mandatory testing of all health care providers on the heels of the 1990 Florida case in which a dentist with AIDS infected three of his patients. Dale Massey, a social worker at the University of Pennsylvania, who is involved in handling AIDS cases, had a personal experience involving a doctor with AIDS. When she scheduled a routine checkup with Dr. Waxman, her personal physician of several years, she was told he was very ill and that another physician would see her. Having professional familiarity with such cases, she deduced that Dr. Waxman must have AIDS. When Dr. Waxman died 6 months later, his illness figured prominently in his obituary. Friends and colleagues knew about his condition, but his patients at the George Washington University Medical Center were never told. Dr. Waxman stopped seeing patients 9 months before he died, but prior to that, he was still involved in patient care and surgery. As a patient, Massey felt misgivings about Dr. Waxman's participation in procedures such as deliveries in which a lot of blood is involved. She contends that the hospital was irresponsible in not telling patients.[14]

(1) Dr. Gail Povar, Head of the Ethics Committee at George Washington University Medical Center, maintains that the hospital behaved ethically and responsibly in withholding this information from patients. "The risk of death in a medical encounter is far less than the risk of death on the highway."[15]

(2) Informing a patient would make the risks appear greater than they really are. Of the 160,000 AIDS cases reported, the case of the Florida dentist is the only one in which a health care provider infected a patient with the AIDS virus. "If the Patient should be told of the AIDS risk, should the patient, also be told of greater risks that exist

in the health care setting? Should the patient be told that the surgeon recently had a heart attack, he [or she] had two drinks the night before, or that he [or she] took an antihistamine that could cause grogginess?" asks Povar.[16]

(3) Since there is some uncertainty in all-human encounters, the patient should only be told about risks that are significant. A patient is more likely to be struck by lighting than contract AIDS from a health care provider. Federal Center for Disease Control (CDC) data on the comparative risks of various diseases suggest that the risk of contracting AIDS in the health care setting is relatively small (24 in 1 million). Other sources put the risk even lower (one or two in 1 million). When compared to the risks of contracting cancer or developing heart disease, the risk of contracting AIDS from a health care provider seems miniscule, indeed.[17]

(4) Dr. June Osborne, a public health specialist, and chairperson for the National Council for AIDS, contends that universal precautions (wearing gloves, gowns and goggles) are sufficient to protect patients. One indicator of the efficacy of universal precautions is the rate of hepatitis B, another blood-borne disease. Since 1987, when universal precautions were instituted, there have been no cases of a health care provider infecting a patient with hepatitis B.[18]

(5) Despite low odds, many hospitals are taking the ethically correct step of notifying patients if health care providers have AIDS. The Johns Hopkins Hospital, in Baltimore, notified 1,800 breast surgery patients when their surgeon, Dr. Rudolph Almaraz, died of AIDS. Two Ohio hospitals offered free testing for patients of a surgeon who had died of AIDS. (So far, none has tested positive.) Dr. Osborne contends that the decision to inform patients is not taken on *moral* grounds, but as a result of liability advice from lawyers.[19]

(6) Despite the assurances of a low risk rate, people are frightened. The deathbed appeal of Kimberly Bergalis, a young Florida woman apparently infected with the HIV during a dental extraction, has drawn much public attention. As a result, the CDC has revised its guidelines. They are no longer leaving it up to the hospitals. At this writing, they have recommended that patients be advised when health care providers performing invasive procedures (for example, dental extraction and other surgeries) are infected, and that these health providers be removed from direct patient care.[20] (Since guidelines on AIDS are subject to constant change, refer to the most current CDC guidelines if you want information on how they may apply to you.) Many infected providers, however, have decided not to follow the guidelines, contending that it "is unfair and unscientifically warranted to have to sacrifice their livelihoods when the danger of transmission to a patient is infinitesimal--much smaller than the danger any doctor faces in treating someone with an unknown history."[21]

e. **The Risk of Health Providers Contracting Acquired Immunodeficiency Syndrome From Patients**. Of the 164,129 cases of AIDS reported to the CDC as of January 31, 1991, about 5 percent have involved health care workers. Fewer than 40 are thought to have been infected on the job.[22] Of those infected on the job, most

incidents have involved being stuck with a needle or contact with blood or blood fluids. Health professionals are increasingly afraid, though the risks are low. Dr. Douglas Whitehead, an urologist in New York City (where the rate of infection is the highest in the nation), performs procedures such as transurethral resections of the prostate. The procedure involves scraping tissue to remove obstruction of urine flow. Frequently, some splattering of urine and blood occurs when removing tissue.[23]

(1) The CDC states that universal precautions should always be practiced. But, Dr. Whitehead says that it is impractical in emergency situations where time is critical. Surgeon Dr. Susan Cutler says, "Accidents are unavoidable in surgery which is a very manual skill. Instruments can easily pierce you. During suturing, to obtain an adequate fixation of tissue and exposure, sharp instruments come in close approximation of one's hands. Some measures have decreased inadvertent needle sticks, such as increased care in the way in which instruments and needles are passed."[24]

(2) The problem is that not everybody is following these procedures. Some studies indicate that 80 percent of all accidents could be avoided if proper sterilization were followed. Other studies show that protective clothing is worn in only half the instances required.[25]

(3) Dr. June Osborne says, "If health care providers took the proper precautions all the time, the rate of infection would go down." The risk of contamination with an infected needle is one in 333, a relatively small risk. Many of these incidents occur when recapping a needle after it has been used. "As prevention measures are perfected, the rate will decrease," says Osborne. "If we had a receptacle for sharps [needles, scalpel blades, and so forth, conveniently located at every bedside] so nobody tried to recap, the rate would be reduced. In many cases, trays are now used to pass instruments. Wounds are stapled rather than sutured.' At the University of California in San Francisco, the frequency of needle stick injuries is being studied,as well as whether double gloving and disinfecting after exposure would make a difference.

(4) Despite the relatively low risks and improved preventive measures, health care providers want even more information. They want to know which patients are infected. Medical ethicist Art Kaplan says, "I know for a fact, that many doctors and nurses are ordering HIV testing as part of a routine screen of blood *without getting patient consent* (Emphasis added.) Twenty-five percent of all patients are tested upon admission to the hospital. This is illegal and unethical."[27]

(5) Dr. Douglas Whitehead contends that such testing shouldn't be illegal. "I have stuck myself, been stuck and stuck others, as all surgeons have. I can think of a relatively recent case in which I stuck a surgeon assisting me and we didn't know the status of the patient. The surgeon is worried, and so am I."[28] As a result, the Centers for Disease Control is issuing, at this writing, guidelines recommending patient testing for hospitals in high risk areas, such as Newark, NJ, New York City, NY, and San Francisco, CA. As the above discussion shows, the debate goes on with no clear-cut solutions in sight.

f. **Distancing Behavior**. The only consolation left for an isolated and dying AIDS patient is the kind word, tender look, or comforting touch that sometimes only a primary care giver can offer. When nurses execute their duties with a detached and guarded concern for the risks of their own exposure, they cannot provide the caring that is so crucial at the very point when the technology side of medicine cannot do much more.

(1) Immediate family members who care for dying AIDS patients in the home have not contracted AIDS, even though they handle soiled bed sheets and come in close contact with the patient.

(2) When health care providers drastically minimize all contact, even those that would benefit the patient without involving risk to themselves, they are not living up to their code of ethics. Fear that distances the health care provider from the AIDS patient to that extent gets in the way of fulfilling the ethical requirements of the job.

g. **Acquired Immunodeficiency/Human Immunodeficiency Virus--Related Bias Growing Faster than the Disease**. A review of 13,000 reported cases of AIDS discrimination, performed by Nan D. Hunter for the American Civil Liberties Union in 1990, revealed that discrimination against people with AIDS has steadily increased. This is the case, even though most people realize that the disease cannot be spread by casual contact. The study revealed that even people who know that the disease is not spread casually will sometimes prevent people with AIDS from keeping jobs, getting housing, insurance coverage, or medical care. About 30 percent of the cases of discrimination were not against those already infected, but against those *perceived to* be at risk, or those who cared for AIDS patients. The cases varied from a dentist who overcharged AIDS patients, to doctors and dentists who would not treat AIDS patients at all, to a woman who lost her job because she volunteered to be a 'buddy" at an AIDS clinic.[30] The number of cases reported increased from less than 400 in 1984 to 92,548 in 1988, the last year for which data were available. The greatest number of reported cases (37 percent) occurred in employment, though no instances of transmission in the workplace (outside the health care setting) have been reported.[31]

(1) Discrimination in health care services accounted for 9.9 percent of all reported discrimination in this study. Health care discrimination included doctors and nurses who refused to treat AIDS patients. The high number of discrimination complaints in health care, especially by dentists and nursing homes, is particularly alarming since health care is an essential service. The report described cases in 25 states and the District of Columbia, including several states in which doctors flatly refused to care for people infected with the virus. Larry Gostin, Head of the American Society of Law and Medicine, says that discrimination in health care can be much more sophisticated, taking the form of "systematic attempts to transfer people to other doctors or hospitals, especially to public hospitals."[33]

(2) The Army provides care to beneficiaries for HIV-positive related problems and for AIDS. According to the Walter Reed Army institute of Research, data gathered between November 1988 and October 1989 indicate that 220 soldiers will become infected with the HIV each year, and that medical costs for each HIV-positive soldier will be at least $250,000.[34]

(3) While HIV-positive patients cannot be refused treatment because military doctors, surgeons, and nurses do not choose their patients; as with any patients, there still can be subtle attitudinal differences that affect bedside manner. Ultimately, these could constitute a subtle, yet not unimportant form of discrimination, contrary to the spirit of the professional code of ethics. In extreme cases, it could constitute a breach of duty to act in the best interests of a patient and to treat all patients with the same measure of respect.

h. **Living Up to an Ethical Ideal**. The examples cited show that the ethical standard (an ideal) may prescribe a certain behavior, e.g., to treat all patients uniformly, while the reality may fall short in some cases. Why? It is because we are sometimes faced with tough choices, or even ethical dilemmas. Then, too, we are human beings, first; health care professionals, second. Our personal standards may conflict with our professional (ethical) standards.

i. **Sources of Morality Often in Conflict With Each other**. Our health care decisions and reactions are colored by our personal values, beliefs, and attitudes. These are, in turn, affected by the family and culture into which we have been born. The sources for morality are numerous (see other column) and more often than not, these sources are in disagreement with each other, generating conflicting opinions of what is right and wrong. Ethics provides standards to help us sort out this confusion.

SOME SOURCES FOR MORALITY

- Personal experience.
- Tradition.
- Family experience.
- Community.
- Education.
- Racial group.
- Ethnic group.
- Age group.
- Geographic region.
- Religion.
- National identity.
- National history.
- National law.

Figure 1-2. Sources for morality

1-4. ETHICS DOES NOT PROVIDE BLACK AND WHITE ANSWERS

The ideals of behavior, embodied in the ethical standard, sometimes place us in conflict with our own personal standards (values, beliefs, attitudes) and the various sources for morality. The answers to ethical questions, such as whether or not patients and health care providers should be screened for the HIV, are not always clear-cut; they often come in shades of gray. Some say that the answers depend on the specific situation, that living up to ethical standards is a question of degree. Others say that some ethical principles are unconditional, that is, they must be adhered to in all cases, without exception. These kinds of questions and answers, and the debate that they generate, touch on the realm of ethics, the philosophic study of what is right and wrong. Ethics attempts to bring to a conscious level the underlying ideals of behavior. Ethics seeks to articulate a clear, consistent, and relevant account of moral conduct, a reasoned account of what is right and wrong. It attempts to disentangle the conflicting web created by the differing sources of morality, and the opinions they generate.

ethics: a disciplined study of morality (what is right and wrong). It attempts to sort out the confusion created by conflicting sources of morality.

morality: conformity to the rules of right conduct.

Section II: HOW ETHICS AFFECTS HEALTH CARE DECISIONS

1-5. TYPES OF ETHICS

a. **Clinical and Biomedical Ethics**. Ethical thinking can be applied to any aspect of life: journalism, politics, health care, the environment, and so forth. When ethics is applied to direct patient care, it is referred to as clinical ethics. When more than direct patient care is implied, the discipline is referred to as biomedical ethics. Broader in scope than clinical ethics, biomedical ethics includes not only health care, but also medical research and biogenetics, and the though ethical dilemmas posed by recent technological advances in those areas.

clinical ethics: a type of ethics that involves identification, analysis, and resolution of moral problems encountered at the bedside.

biomedical ethics: a philosophical study of what is right and wrong in modern biological sciences, medicine, health care and medical research.

(1) Ethics related to health care has existed since the days of Hippocrates (circa 400 B.C.). But the recent and rapid changes in the biological sciences and health care, brought about by scientific, technological, and social developments, have challenged many of the traditional ideas of moral obligation held by health professionals and society in general.

(2) Medicine, for one, keeps changing the pattern of disease and dying. The issues that biomedical ethics must deal with today, such as when life begins and ends, are less easily resolved than those that ancient forms of medical ethics had to consider.

b. **Professional Ethics**. Professional ethics defines the right behavior for a given profession, that is, any occupation in which a person earns a living.

(1) Professions control entry into occupations by certifying candidates as knowledgeable and skilled (in certain technologies). They formalize the professional code of ethics in a written document, which also covers the caring and values aspects of a profession.

(2) Through codes of ethics, professions specify and enforce primary responsibilities, obligations and seek to ensure that people (patients), who enter into relationships with their members (health providers), will find them competent. Through codes of ethics, professions try to enforce norms for acceptable behavior.

professional ethics: a set of standards of professional conduct set down in codes.

professional code of ethics: a statement of role morality for a given profession, as expressed by members of that profession, rather than external bodies such as government agencies.

c. **Descriptive Ethics**. Descriptive ethics looks at how people actually reason and act. Anthropologists, sociologists, and historians record the way moral codes and individuals and societies express attitudes.

d. **Normative Ethics**. Professional ethics, such as biomedical, journalistic, or business ethics, is normative (rather than descriptive) in nature. Normative ethics looks at what professionals ought to be doing in their respective fields. Normative ethics formulates broad ethical theories, then it specifies moral principles and rules that provide justification for particular actions. The principles and rules, outlined in the code of ethics, serve as action-guides (guides to ethical behavior). Normative ethics attempts to answer the question: “Which action-guides are worthy of moral acceptance and for what reasons?”

normative ethics: a type of ethics that formulates ethical theories; and specifies behaviors that support ethical standards.

1-6. ROLE OF THE MEDICAL ETHICIST

a. Before 1970, medical ethics as a formal field did not exist. The medical profession was considered ethical by its very nature, with ethical dilemmas handled in the privacy of the doctor-patient relationship. But the advances in medicine that gave physicians dramatically increased power over life and death brought new challenges to the profession. Issues once handled in the privacy of the doctor's office, such as the extent of treatment of seriously deformed infants, became a matter of general public interest and comment. With the difficult choices presented by modern medicine and public exposure, the need arose for a way of sorting out underlying ethical principles in order to make morally based decisions. A committee in Seattle, for example, choosing candidates for kidney dialysis realized they needed help when they found themselves choosing candidates based on supposed worth to society (men over women, upstanding citizens over prostitutes, married people over singles). Another example involves the advances in medical neonatology that result in premature and badly handicapped infants surviving to face painful, difficult lives.

b. Medical ethicists are employed by hospitals to oversee conferences, conduct teaching rounds and committee meetings. They help the health care team deal with such ethical issues as: the right to choose treatment, the right to know who is treating you, informed consent, confidentiality, treatment of severely handicapped infants, when to withdraw or withhold treatment for an adult, and the right to die. The medical ethicist meets with medical team members (working in highly sensitive areas) and senior faculty members (some specializing in ethics, others in medicine) to work out some of the difficult ethical dilemmas facing doctors today.

c. Sometimes the choices have been made, and the case is reviewed for educational purposes. Other times a decision has yet to be made, with a life hanging in the balance. The ethicist doesn't tell doctors what to do. Rather, he or she helps clarify the problem, sorting out the underlying moral principles so that a consistent moral basis for a decision can be developed. According to Ruth Macklin, Medical Ethicist In Residence at Albert Einstein College of Medicine, "Sixty percent of medium and large hospitals in the country have an ethics committee…. [They] make policy, [and] hear cases…. Some 300 people identify themselves as clinical bioethics consultants--people who are actively involved in ethics consultation in a medical setting. They may be philosophers, doctors, nurses, lawyers, or clergy.

1-7. PROFESSIONAL CODES OF CONDUCT

a. **Ethical Behavior, Good Conduct, and Responsibilities to Other Members of the Profession**. A code of conduct spells out ethical behavior. But, it also specifies rules of etiquette (good practice), patient's rights, and responsibilities to other members of the profession. If you consider the code of ethics for x-ray technologists (figure 1-3), you will see examples of these different types of standards.

b. **Professional Codes vs General Moral Codes**. Whereas professional codes govern the behavior of groups such as radiographers, nurses, psychologists and physicians, general moral codes govern whole societies and apply to everyone alike. A general moral code consists of a society's cherished moral principles and rules. Professional codes specify action-guides for a particular group, such as social workers. These action-guides should reflect the more general principles and the rules of society at large. An example of a rule from the general moral code would be, "You have an obligation to keep promises."

(1) Human need and professional obligation. Some of the broad ethical theories of the general moral code relate to human need and professional obligation. It is assumed, for example, that human life is worth saving, that the condition of our fellow man or woman is worth alleviating, and that certain human rights exist. It should be noted that while the broad ethical theories are not explicitly stated in the code of ethics, reference to these theories can provide justification for the principles set forth in these codes.

*CODE OF ETHICS FOR X-RAY TECHNOLOGISTS

GOOD PRACTICE	1. Conduct yourself in a professional manner, be responsive to patients, and support peers in order to give quality care.
ETHICS/PATIENTS	2. Advance the main objective of the profession: providing care with respect for the dignity of mankind.
ETHICS/PATIENTS	3. Deliver care without regard to patient's personal attributes, nature of the illness, sex, race, creed, religion, or socioeconomic status.
GOOD PRACTICE	4. Base practice on sound theoretical concepts, use equipment as intended apply procedures appropriately.
GOOD PRACTICE	5. Assess situations, exercising care, discretion, and judgment; take respon- sibility for decisions; act in the best interests of the patient.
GOOD PRACTICE/ ETHICS	6. Act as an agent, obtaining pertinent information from the physician to aid in diagnosis and treatment management; recognize that diagnosis and interpretation are outside the scope of the profession.
GOOD PRACTICE/ PATIENT'S RIGHTS/ MEMBERS	7. Observe accepted standards of practice in using equipment and applying techniques. Limit radiation exposure to the patient, self, and colleagues.
ETHICS/PATIENT'S RIGHTS	8. Practice ethical conduct appropriate to the profession; protect the patient's right to quality care.

* This Code is paraphrased for brevity.

Figure 1-3. Code of Ethics

(2) Patient's rights. One of the tenets of the general moral code (in this country) is that the recognition and observance of the patient's rights will contribute to more efficient and better quality care, and greater patient satisfaction. Patients bring to their medical care their own perspective of their best interests which should, at least, be on an equal footing with the medical establishment's view of the patient's best interest. Thus, the patient's bill of rights has evolved as an adjunct to professional codes.

c. **Criticism of Professional Codes.**

(1) Failure to reflect the full range of moral principles. Do codes specific to the areas of science, medicine, and health care express *all* of the essential principles and rules that are important to society? Many medical codes have a lot to say about doing what is right or good, and about confidentially. But only a few have anything to say about other important principles and rules, such as truthfulness and respect for patient autonomy (self-rule or self-determination).

(2) Not enough emphasis on patient's rights. There have been attempts of late to incorporate some of the overlooked principles and rules by formulating statements of a patient's rights, which cover the principles of respect for autonomy and rules of truthfulness. But such statements are usually incomplete and fail to present the whole range of moral principles.

(3) Codes written by the professionals themselves and not subject to outside scrutiny. Since the time of Hippocrates, physicians have generated narrow codes that involve no scrutiny by those whom physicians serve. These codes have rarely appealed to more general ethical standards or to any authority beyond the deliberations of physicians. Says ethicist Ruth Macklin, "…the medical expertise of physicians does not automatically confer moral expertise on their decisions and actions. Any reflective, thoughtful person is potentially as good a decision-maker as any other."[37]

(4) Too vague and abstract. Codes have been traditionally expressed in abstract terms that are subject to completing interpretations. Jay Katz is a psychiatrist who complied materials on human experimentation and the fate of victims of Nazi Germany's Holocaust. He maintains that training which health care providers receive in the complex issues of ethics and legal rights in inadequate, and that the codes are vague and abstract in comparison with the intricacies of the law on such issues as the right to privacy and confidentiality. He believes that more training in this area, beyond what is covered in traditional codes, is needed to provide meaningful guidance for research involving human subjects.[38]

1-8. THE PATIENT'S BILL OF RIGHTS

a. **Specific Aspects of the Patient's Hospital Stay**. As stated earlier, it has been recognized that if the patient's rights were addressed, the result would be better quality and more efficient care, as well as increased patient satisfaction. A comparison between the code of ethics for x-ray technologists adopted by the American Registry of Radiologic Technicians and the patient's bill of rights will reveal some obvious differences in content and style (see Appendixes A and B). The professional code covers ethics, good conduct, and responsibilities to other members of the profession. The language of the code is abstract. By comparison, the bill of rights is worded much more concretely. It zeroes in on specific aspects of the patient's stay, for example, treatment in an emergency, access to records. In addition, it spells out not only ethical rights (ethical standards of the profession that aren't actually required by law), but also legal rights (recognized by statute).

b. **Health Care Providers Held Accountable for Patient's Rights.** To comply fully with the ethical requirements of your profession, you must be aware of a patient's rights. This is true because the patient's bill of rights complements the code, filling in the gaps and making concrete what is left unsaid and, thus, open to interpretation in the code. Every hospital has its own version of a patient's bill of rights, outlining more or less, the same rights (with some variation depending on the hospital). These are posted, and a copy is given to each patient upon admission. Since patients are well aware of their rights, you must be familiar with them as well.

c. **Specific Tenets of the Patient's Bill of Rights.**

(1) Prompt care in an emergency (principles five). Consider principle five of the patient's bill of rights. A patient cannot be turned away by a hospital in an emergency, e.g., for lack of insurance. If a patient suffers injuries or death resulting from a lack of prompt care, the individual (or family) can sue for damages. "The Case of Rod Miller" below, illustrates how health care can fall short of the ideals embodied in the professional code of ethics and the patient's bill of rights.

THE CASE OF ROD MILLER

Rod Miller cut his foot on the rocky jelly at Rehoboth Beach, Delaware, during the summer of 1987. He expected that the nearby emergency room doctors would quickly take care of him. But the orthopedic surgeon, nothing Rod's "demeanor" and the male friend who accompanied him to the hospital, refused to perform the necessary surgery unless Rod first had an AIDS test. So Rod had to take a helicopter to George Washington University Hospital in Washington, D.C., where he underwent surgery to repair a severed tendon.

The delay resulted in permanent damage to his foot, and so his attorney filed a complaint with the civil rights office of the US Department of Health and Human Services. According to the CDC, as of this writing 18 health care workers in the US and abroad have been infected with the AIDS virus through on-the-job exposure, a small number but still enough to make some doctors concerned about their risks.[40]

(2) Procedures and risks explained in layman's terms: patient's consent obtained (principle 6). If a radiographer has to inject a patient with a contrast agent for a special study for kidney pain, he or she must first explain that the contrast agent can be toxic in some cases, causing an allergic reaction, shock, and possibly death. He or she must also explain why the contrast agent is necessary in order to obtain the required study. Obtaining an explanation from the health care provider about intended procedures is a legal right in the US and most Western European nations. But in England, this right was recently denied by the House of Lords, much to the shock of

medical legal experts in West Germany, France, and the US[39.] So, keep in mind that patient's rights are by no means universal. They reflect the overall values of the society that generates them.

(3) The right to an interpreter (principle nine). When a radiographer instructs a patient to take a deep breath and then blow out, he or she had better be sure that the patient understands because it is crucial to getting an accurate x-ray. If there is a language barrier, the x-ray technologist must ensure that an interpreter is on hand to provide necessary translations.

(4) The right not to be experimented upon without prior consent. Consent of the subject is mandatory for patients participating in experimental research. But the frequency and manner in which scientific studies, such as randomized controlled trials (RCTs), are done in different countries reflect to some extent national values.

(a) Randomized controlled trails, in which subjects are divided into two or more groups, the groups treated differently, and the results compared, provide the most useful answers. (Randomized control trails apply to nontherapeutic research, which offers no prospect of benefit to the subject, and to therapeutic research, which offers some prospect of medical benefit to the patient-subject.) Many doctors question the use of RCTs in therapeutic research because patients must be treated differently, with some not treated at all (for the group receiving a placebo).[41]

(b) For physician-researchers conducting therapeutic research in the US, the first ethical obligation is to the best interests of the patient. (A rights-based morality prevails.) Thus, a properly designed, controlled drug trail would be one in which neither of the proposed therapies could be regarded as definitely better than the other. In these trails, patient-subjects in the control group would receive the standardized therapy, rather than a placebo. Thus, there is a benefit to the patient-subject, regardless of whether he/she receives the standardized or the experimental therapy.[42] (If the physician-researcher should feel that the new treatment is more or less preferable to standard therapy, then there is a conflict between his or her duty to the patient, and to the study.) [43]

(c) In Great Britain, where RCTs are done more frequently than in any other country (with Scandinavia and the US closed behind), ethical obligations are seen in utilitarian rather than rights-based terms. The British are more likely to conduct RCTs in which one group in definitely not getting beneficial therapy.[44] In a country with socialized medicine, the good of society as a whole is given more importance than the potential benefit to any individual patient-subject. There is also a general skepticism about the potential benefit of any new therapy.

(d) In France, on the other hand, where the rights of the individual are highly valued, and strict privacy laws make data collection virtually impossible, RCTs are much less common.[45]

A MODEL OF THE PATIENT'S BILL OF RIGHTS

1. Legal right to informed participation in all decisions in involving the patient's health care program.

2. Right of all potential patients to know what research and experimental protocols are used in the facility and alternatives available in the community.

3. Legal right to privacy respecting the source payment; access to the highest degree of care without regard to the source of payment.

4. Right of a potential patient to complete and accurate information concerning medical care and procedures.

5. Legal right to prompt attention, especially in an emergency situation.

6. Legal right to a clear, concise explanation of all proposed procedures in layman's terms, including risks and serious side effects, problems related to recuperation, and probability of success. The right not to be subjected to procedures without voluntary, competent, and understanding consent in written form.

7. Legal right to clear complete, and accurate evaluation of one's condition and prognosis without treatment before consenting to tests or procedures.

8. Right to know the identify and professional status of all those providing service. (Personnel must introduce themselves, state their status, and explain their role in the care of a patient. Part of this right is the right to know the physician responsible for care.)

9. Right to an interpreter.

10. Legal right to all the information in the patient's medical record while in the health care facility, and the right to examine the record upon request.

11. Right to discuss one's condition with a consultant specialist at one's own request and expense.

12. Legal right not to have any test or procedure designed for educational purposes rather than for one's own direct personal benefit.

Figure 1-4. Patient's Bill of Rights (cont).

13. Legal right to refuse any drug, test procedure, or treatment.

14. Legal right to both personal and informational privacy with respect to: the hospital staff, other doctors, residents, interns and medical students, researches, nurses, other hospital personnel, and other patients.

15. Right of access to people outside the health care facility by means of visitors and telephone. Right of parents to stay with children and relatives to stay with terminally ill patients 24 hours a day.

16. Legal right to leave the health care facility, regardless of physical condition or financial status, although a request for signature of release documenting departure against the medical judgment of the patient's doctor or the hospital may be made.

17. Right not to be transferred to another facility, unless one has received a complete explanation of the desirability and need for the transfer, the other facility has accepted the patient for transfer, and the patient has agreed to transfer. If the patient does not agree, the patient has the right to a consultant's opinion and the desirability of transfer.

18. Right to be notified of discharge at least 1 day before it is accomplished, to demand a consultation by an expert on the desirability of discharge, and to have a person of the patient's choice notified.

19. Right to examine and receive and itemized and detailed explanation of one's total bill regardless of source of payment.

20. Right to competent counseling to help one obtain financial assistance from public or private sources.

21. Right to a timely prior notice of the termination of one's eligibility for reimbursement for the expense of his/her care by any third-party payer.

22. Right at the termination of one's day stay to a complete copy of the information in one's medical record.

23. Right to have 24-hour-a-day access to a patient's rights advocate who may act on behalf of the patient to assert or protect the rights set out in this document.

Figure 1-4. Patient's Bill of Rights (concluded).

(5) Privacy regarding source of payment and quality care without regard to source to of payment (principle 3). Not all hospitals will include the right. Private hospitals routinely request health insurance and other information before admitting a patient unless it is an emergency. Courts are constantly confronted with cases in which this right is violated. Those who cannot pay are refused care, and advised to go to a state-subsidized hospital.

(6) The right to competent counseling on financial assistance (principle 20). If a patient is in need of a liver transplant, he or she will ask the facility to make it known that a donor and/or money is needed. The hospital will assist in this search.

1-9. ETHICS IS NOT FLUFF; IT DEALS WITH REAL-LIFE ISSUES

We tend to assume that ethics is removed from the concerns of real life. (Most of us don't study ethics formally in high school. And, we associate ethics with the philosophy or religion department a university). To the uninitiated, ethics may seem lofty and abstract. But if you take the time to explore it; you will discover that it is quite practical in that it attempts to grapple with real (and difficult) issues of daily life. It is not so much that ethics is abstract, it's that the questions ethics tries to answer are not so easily resolved. Ethics forces us to bring to a conscious level our own underlying assumptions about what is right and wrong, the ideal standards of behavior that we normally take for granted.

1-10. ETHICS GRAPPLES WITH TOUGH QUESTIONS

a. **Euthanasia**. Consider the thorny question of euthanasia (mercy killing). According to Lawrence K. Altman, M.D., "The public seems to be of two minds about doctor-assisted suicide. People expect physicians to be healers, not takers of life, and they applaud compassionate doctors who admit that they would help patients end their suffering. While they have reservations about being treated by a pro-euthanasia doctor they assume the right to die and expect physician's help in carrying out their wishes."[46]

(1) Patients are ambivalent. They seem to be saying: "Have the utmost respect for life, but do otherwise when we tell you:" What about the law? Howard R. Relin, Monroe County District Attorney investigating a doctor-assisted suicide case says: "These are very difficult cases because the law is in conflict with people's perception of their right to die.[50] With the law and the patient's perception of his or her rights in conflict, physicians conclude that public policy and medical practice are out of step. University of Minnesota ethicist Arthur L. Kaplan states: "More than a dozen doctors have confided in [me] about their role in responding to requests from conscious, mentally clear patients to help them die. The doctors want the stories known to stimulate more public discussion because they believe public policy and medical practice are out of step."[51]

(2) Dr. Quill's story, below, shows why ethical issues do not have simple black and white answers.

DR. QUILL AND THE ACUTE LEUKEMIA PATIENT:
PERSONAL AND PROFESSIONAL ETHICS IN CONFLICT

Dr. Timothy Quill, a Rochester, New York physician, described in The New England Journal of Medicine how he had prescribed barbiturates to help a patient kill herself. It was the case of personal and professional ethics in conflict in the case of Diane, a long-term patient suffering from acute myelomonocytic leukemia.

Diane had been a patient of Dr. Quill's for over 8 years. He had helped her overcome a life-long battle with alcoholism and depression, and had seen her take control of her life, realizing professional success and deepened personal ties to her husband, college-age son, and several friends.

Dr. Quill chose to write up this experience in indirectly assisting Diane to take her own life. Like others who are speaking out, he feels that the secrecy that was good practice in another era may not be inappropriate for a public that is much better informed about health care. [47] In an interview on National Public Radio, the Editor of The New England Journal of Medicine conceded that the decision to publish Quill's article indicates that the journal feels the issue of the physician's role in ensuring death with dignity warrants more open consideration.[48]

Diane was a clear thinker, a good communicator, and an individual who had overcome vaginal cancer as a young woman, At Dr. Quill's suggestion, she saw a psychologist who confirmed that she was of sound mind. Dr. Quill, who once directed a hospice, also had extensive discussions with Diane's husband and son about her illness and options. After much deliberation with her family and Dr. Quill, she opted to forego any treatment, deciding that the one-in -four change of recovery was not worth the pain involved or the three-in-four risk of a painful death.[49]

During the time remaining to her, she wished to maintain control of herself and, when that was no longer possible, to die in the least painful way. Since fear of a lingering, painful death would prevent her from enjoying her remaining days, she requested information on suicide. Dr. Quill referred her to the Hemlock Society. The following week, when she came for a doctor's visit, she sought a prescription for barbiturates for sleep. Dr. Quill made sure that she knew how to use the barbiturates for sleep, and also the amount need to commit suicide. "I wrote the prescription with an uneasy feeling about the boundaries I was exploring--spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

(Continued)

DR. QUILL AND THE ACUTE LEUKEMIA PATIENT:
PERSONAL AND PROFESSIONAL ETHICS IN CONFLICT
(Concluded)

In the next few months, Diane spent a lot of time with her college-age son, who stayed home from college, her husband, who opted to work at home, and closed friends. But as bone pain, weakness, fatigue, and fevers began to dominate her life, she contacted close friends and asked them to come over to say good-bye. In a tearful good-bye to Dr. Quill, she said "she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer."[54] Two days later, she said her final good-byes to her son and husband, and asked to be left alone for an hour. An hour later, they found her on the couch in her favorite shawl, at peace at last. They mourned the unfairness of her illness and premature death, but felt that she had done the right thing, and that they were right to cooperate with her in her resolve to attain control over health care decisions, and to attain a death with dignity.

Dr. Quill concludes, "She taught me that I can take small risks for people that I really know and care about" by helping indirectly to make it possible, successful, and relatively painless. "I wonder" he asks, "how many families and physicians secretly help patients over the edge into death in the face of such severe suffering? [55]

(a) It is felt by many ethicists and experts that in many ways, Dr. Quill "has significantly advanced the debates over doctor-assisted suicide."[52] Dr. Quill advised his patient to see a psychologist to ascertain that she was of sound mind. He also had extensive discussions with Diane's husband and son about her illness and options. And, he had known Diane for over 8 years. His, in a sense, is a model case.

(b) Dr. Quill had the advantage of having known his patient over many years. In this day and age, when patients often change doctors, when can a doctor safely say that he or she really knows the patient? There are no rules for doctor-assisted suicide. It is still officially considered a violation of professional ethics that can mean the loss of one's medical license.

b. **Moral Imperative vs Self-Interest**. How does a physician reconcile his or her personal ethics with the professional code of ethics? Is human life valuable, no matter what the quality of that human life? Is that an unconditional moral imperative (requirement) without exception? Or does the individual's right to self-determination and a quality of life override the sanctity of life issue? Are these two equally valid imperatives (the value of all life vs. self-determination/ quality of life)? Or is the quality of life/self-determination issue a matter of self-interest? The official stance is the latter--all life has value, no matter what the quality of that life. The issue of self-determination/qualify of life is considered to be a matter of personal self-interest.

Continue with Exercises

EXERCISES, LESSON 1

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response(s) that best answer(s) the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. As a health care provider, you must be concerned not only with the technical aspects of your job (the technology), but also the caring, and the underlying (professional and personal):

   a. Habits.

   b. Methods.

   c. Teachings.

   d. Values.

2. Our basic ideas about what is right and wrong are determined by our _____, goals or ideals upon which we base decisions affecting our lives.

   a. Customs.

   b. Values.

   c. Laws.

   d. State of mind.

3. The x-ray technologist must be especially vigilant in following principles of _____and discretion when alone with a patient and positioning him or her for x-rays.

   a. Ethical behavior.

   b. Good practice.

   c. Human compassion.

   d. Paternalism.

4. If a patient inquires about the results of the x-rays that an x-ray technologist has taken, the radiographer should:

   a. Refer the patient to the attending physician.

   b. Tell the patient that the x-rays are fine.

   c. Be honest and state if the x-rays suggest a health problem.

   d. Show patient the film and point out what is depicted.

5. In ethics, the moral imperative should win out over:

   a. Patient's rights.

   b. The professional code of ethics.

   c. Self-interest.

   d. Beneficence.

6. For which type of patient is relatively easy to live up to the ethical ideal of providing the best possible care, regardless of the patient's condition or circumstances?

   a. A smelly alcoholic who makes repeat visits to the hospital between alcoholic binges.

   b. A difficult patient who complaints a lot, and doesn't cooperate with the treatment plan.

   c. An AIDS patient who is perceived as a threat to the health care provider's own health.

   d. A clean, cooperative patient, hospitalized for a herniated ulcer.

7. Disagreement about whether or not it is ethically appropriate to screen patients for the human immunodeficiency virusbefore treating them shows that:

    a. Clear-cut definitive answers to ethical questions are not always readily available.

    b. Cost-effectiveness has not been considered.

    c. Health care providers are placing themselves above morality.

    d. The application of morally right behavior to daily is not difficult at all.

8. Which of the following statements accurately describes ethics?

    a. A science, which provides definitive answers, to life and death questions.

    b. A disciplined examination of what is right and wrong; it seeks to sort out the confusion generated by various sources of morality.

    c. An area of inquiry requiring knowledge of philosophical treatises.

9. The various sources of morality (personal experience, tradition, religion, and so forth) are usually:

    a. In agreement with each other.

    b. A clear and consistent basis for defining ethical behavior.

    c. In conflict with each other.

    d. Easy to reconcile with each other.

10. The study of ethics is useful because it brings to conscious level underlying.

    a. Laws.

    b. Pet peeves.

    c. Ideals of behavior.

    d. Memories.

11. The _____ Act protects health care providers at medical treatment facilities in COUNS from being named in lawsuits and suffering individual pecuniary liability.

    a. Gonzales.

    b. Feres.

    c. MTF.

    d. Monroe.

12. Health care providers sued outside CONUS:

    a. Are discharged.

    b. Are referred to local authorities.

    c. Receive a defense and/or suitable insurance from the Department of Justice.

    d. Are turned over to the ethics committee.

13. _____ identifies, analyzes, and resolves moral problems that arise in the care of particular patient.

    a. Normative ethics.

    b. Clinical ethics.

    c. Descriptive ethics.

    d. Biomedical ethics.

14. Biomedical ethics is the philosophical study of what is right and wrong in the biological sciences, medicine, health care, and:

    a. Education.

    b. Social services.

    c. Various professions.

    d. Medical research.

15. In modern times, clinical ethics has been complicated by the manner in which modem medicine has changed the pattern of:

    a. Disease and dying.

    b. Experimentation.

    c. Space travel.

    d. Conducting warfare.

16. A professional code of ethics (statement of role morality for a given profession) is written by:

    a. Government agencies.

    b. Lawyers.

    c. Clients/patients.

    d. Members of the profession.

17. A code of ethics spells out ethical behavior, rules of etiquette (good practice), and responsibilities to:

    a. Patients/clients.

    b. Other members of the profession.

    c. The community.

    d. Oneself.

18. In their broadest application, general moral codes govern:

    a. All member of society.

    b. Specific professions.

    c. Religious sects.

    d. Government officials.

19. A criticism of the professional codes is that there is not enough emphasis on:

    a. The obligations of professionals.

    b. The obligations of the patients.

    c. Patient's rights.

    d. Abstract principles.

20. Generally, each _____ has its own version of a patient's bill of rights.

    a. MEDDAC.

    b. Municipality.

    c. Profession.

    d. Hospital.

21. A copy of the patient's bill of rights, which includes both ethical and _____ rights, is given to each patient.

    a. Legal.

    b. Historical.

    c. Medical.

    d. Provisional.

22. A health care professional should uphold his or her professional code of ethics and the patient's bill of rights to ensure the _____ performance of duties, consistent with the tenets of good practice, and with responsibility to both other members of the profession and the patient.

    a. Efficient.

    b. Effective.

    c. Ethical.

    d. Expedient.

23. A need arose for _____ as a result of the difficult choices presented by modem medicine, and the need to sort out underling ethical principles in order to make morally based decisions.

    a. Medical ethicists.

    b. Professional code of ethics.

    c. A patient's bill of rights.

    d. Hospital lawyers.

24. A radiographer would be violating the code of ethics and/or the patient's bill of rights by:

    a. Refusing to comment on the results of the patient's x-rays.

    b. Explaining the reasons for administering an IVP injection, as well as possible adverse reactions.

    c. Asking an interpreter to be present during the positioning of a non-English speaking patient.

    d. Commenting on a patient's behavior during administration of a procedure in the presence of other patients.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1

1. d (para 1-c)
2. b (para 1-c)
3. a (para 1-1a, fig 1-1)
4. a (para 1-2b)
5. c (para 1-2c)
6. d (paras 1-3a, b)
7. a (para 1-4)
8. b (para 1-4)
9. c (para 1-3h, fig 1-4)
10. c (para 1-4)
11. a (para 1-1e)
12. c (para 1-1e)
13. b (para 1-5a)
14. d (para 1-5a)
15. a (para 1-5a)
16. d (para 1-5b)
17. b (para 1-7a)
18. a (para 1-7b)
19. c (para 1-7c (2))
20. d (para 1-8b)
21. a (para 1-8b)

22. c (para 1-7b)

23. a (para 1-6a)

24. d (figure 1-3, principles 2, 5, & 9)

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End of Lesson 1

LESSON ASSIGNMENT

LESSON 2	The Sources and Applications of Ethics.
LESSON ASSIGNMENT	Paragraphs 2-1 through 2-19
LESSON OBJECTIVES	After completing this lesson, you should be able to:

2-1. Identify the definitions of values, beliefs, and attitudes.

2-2. Identify the difference between a terminal and instrument value.

2-3. Identify the influence of values, beliefs, and attitudes on the practice of health care.

2-4. Identify the influence of culture on the way health care is practiced in different countries.

2-5. Identify the role of race, religion, sex, age group, culture, and family of origin in forming ethical values, beliefs, and attitudes.

2-6 Identify the common feelings that affect patients.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 2

Section I. VALUES, BELIEFS, AND ATTITUDES

2-1. THE CONFLICTING SOURCES OF MORALITY

The sources for morality (personal experience, family tradition, community, ethnic and racial groups, geographic region, religion, national identity, history, and national law) form a patchwork that is more often in conflict than in agreement. This conflict often makes it hard to come to a clear-cut decision on what is ethically right. "Ethics seeks to get beyond the conflicting opinions generated by these sources of morality, to formulate a logical and coherent assessment of what is morally right or wrong in a given situation."[1] It is important to understand how the underlying sources of morality affect our values, beliefs, and attitudes about what is right and wrong.

2-2. VALUES, BELIEFS, AND ATTITUDES COMPRISE ONE'S PHILOSOPHY OF LIFE

a. **An Individual's Orientation to Life**. When Dr. Quill* assisted his terminal leukemia patient, Diane, to commit suicide, he found his professional code of ethics and personal philosophy (the values, beliefs, and attitudes that each of us carries along in life) to be in conflict.

b. **Values**. As stated earlier, values represent ideals or goals upon which we base decisions affecting our lives. Values provide criteria for making choices based on our ideas of right and wrong. We give expression to our values by the choices we make. Values develop through the interplay of desires, goals and environment.[2] It is through life and gained experiences that we develop our values. Some core values stay the same throughout our adult lives. Others, such as personal growth and career development values, evolve over a lifetime and are subject to change. Thus, some choices made later in life does not necessarily reflect the values held early on. Values may be terminal or instrumental.

(1) Terminal values. Terminal values deal with end-states such as the quality of life, job satisfaction, material success, and achievement. Consciously opting for a job that permits creativity over one that offers a high salary means that you value personal satisfaction more than monetary rewards as an end-state. The *choice* you make depends on *what you value*.

(2) Instrumental values. Instrumental values deal with modes of conduct. If a hospital administrator values efficiency above all else, decisions that ensure the smooth functioning of the hospital bureaucracy may be made, even if they adversely affect the immediate needs of the patient.

terminal value: a value based on a decision to choose one end-state of existence in favor of another, that is, quality of life versus sanctity of life.

instrumental value: a decision to choose one *mode of conduct*, e.g., honesty, cooperation, self-control, over another.

CHARACTERISTICS OF HUMAN VALUES

1. Values are often vaguely defined by an individual.
2. Values are often defined in terms of concepts.
3. Values support individual needs. An individual tries to satisfy those needs through actions consistent with a particular value.
4. Values are often acted upon to satisfy the individual's need for security, stability, control, and respect for his or her rights as a human being.
5. Values change as needs and circumstances change.
6. Values may be internalized through learning or adopted as a result of life experiences.

Figure 2-1. Characteristics of human values.

c. **Beliefs**. A belief is the conviction that something is true. The most important characteristics of a belief is that the believer considers it to be true, whether or not it is, in fact, true. Where as values are dynamic, having a role to play in decisions and future choices and "applying to a wide variety of situations and activities, beliefs only apply to specific statements of fact. If the statement of fact changes, the belief statement of fact changes. A value can remain the same while growing and developing through a great variety of activities and situations."[3]

belief: the conviction that something is true. Beliefs are expressions of what people think about an issue, object or a person. We all tend to feel that what we believe is true!

FIVE TYPES OF BELIEFS

1. PRIMITIVE BELIEF (TAKEN FOR GRANTED).

*I live in the US.
*The earth revolves around the sun.

2. PRIMITIVE UNVERIFIABLE BELIEFS

*Last night I boarded an unidentified flying object (UFO).
*I know I'll be a famous writer someday.

3. AUTHORITY BELIEFS

*I am a Jehovah's Witness.
*The American Medical Association is the ultimate authority on medical issues.

4. DERIVED AUTHORITY BELIEFS

*As a Jehovah's Witness, I am against blood transfusions.
*Aromatherapy is not a credible treatment--the AMA does not recognize it.

5. INCONSEQUENTIAL BELIEFS (PERSONAL TASTE)

*Chocolate almond is the best flavor.
*There's nothing like the mountains.

Figure 2-2. Types of beliefs.

d. **Attitudes**. An attitude is "the result of a [number] of beliefs that mesh together to form a given attitude."[4] For example, John, the son of Irish immigrants has a strongly positive attitude toward the police. This attitude is based on stories his father and grandfather told him about the way the local police went out of their way to look out for the neighborhood. This, combined with John's own experiences as a child and through readings, leads him to a positive attitude. A positive attitude is not a value. If John valued the police, he'd see to it that it played a role in his own life. He'd join the police or become active in an organization that fostered ongoing interaction with the police. Values help to shape attitudes, not vice versa. In the police story, the underlying values of the work ethic (fairness, justice, and a respect for authority) contributed to John's positive attitude toward the police.

attitude: a grouping of beliefs around a specific object or a situation; how people feel about something.

2-3. ETHICAL VALUES VARY BY FAMILY, SEX, RACE, AGE GROUP, NATIONALITY, AND SO FORTH.

a. **Dutch Views on Euthanasia**. If you go to the Netherlands, you will find that the medical and legal communities hold a much more tolerant view of euthanasia (mercy killing). That is because the values, beliefs, and attitudes of the culture, as a whole, predispose them toward such a viewpoint.

(1) The Dutch people call it "the gentle death." Every year in the Netherlands, physicians perform euthanasia on 2,000 to 5,000 people. Patients who are near to death account for most cases, but recently people with chronic bronchitis, multiple sclerosis, and debilitating rheumatism have also been granted their wish to die. So open is the idea now (with two-thirds of the Dutch people favoring this practice) that 2 years ago, the Royal Dutch Pharmacists' Association published a physician's guide detailing the most efficient and least painful drugs for use in carrying out mercy killing. Officially, euthanasia is against the law (the penalty 12 years in prison). "But while Dutch lawmakers feel the taking of a life should remain an answerable offense, physicians routinely satisfy prosecutors by following court guidelines for pleading 'conflict of duty'."[5]

(2) The right to die as part of the patient's bill of right. "The Dutch contend that a patient's justifiable wish to die outweighs any attempt to prolong life."[6] By following guidelines resulting from a case that came to trial in 1972, physicians will not be charged. The three main criteria for euthanasia in the Netherlands are as follows: 1) there must be an explicit and a repeated request by the patient to exercise euthanasia; 2) the physical pain or the mental pain must be severe and without hope of relief (the patient's decision must be of free will and enduring); 3) all other options must either be exhausted or be refused by the patient (the physician must consult another physician and must record for the local prosecutor all events leading up to the final hour). In the Netherlands, then, the ethical system gives higher importance to the rights of individual self-determination and the quality of life. These are viewed as higher moral imperatives than the intrinsic sanctity of life.

(3) Accounting for ethical differences among nations. As you can see, ethical values are culturally based. Heleen Dupuis, Professor of Bioethics at the University of Leiden (in Holland), explains the reason for national differences on euthanasia. "Before 1940, most people died quickly from some infections without much pain. Now it takes people much longer to die. Some of our cases are AIDS victims. But

mostly, it is still cancer patients who are living longer. Medicine keeps changing the pattern of disease and the pattern of dying. I think in America you have such an enormous belief in medical science that you look upon it and say, 'Isn't it wonderful, it can do anything.' That's one reason why there is so much aggressive effort in the system....We, in the Netherlands, look at medical science and say, 'It is indeed wonderful, but it has its limits.' If you always vote for life, you never accept death, and of course we all must."[8]

b. **Soviet Views on Euthanasia**. In 1989, six American philosophers specializing in medical ethics met with fifty Soviet professionals (physicians, philosophers, and others) working on issues relevant to medical ethics. They met under the auspices of the International Research and Exchanges Board and the Institute of Philosophy of the Soviet Academy of Science. While Soviet medical ethics cannot be interpreted entirely on the basis of this series of encounters, it does suggest the direction of Soviet thinking in this area.

(1) A strongly anti-euthanasia posture. For the Soviets in this group, active killing and withholding or withdrawing treatment were the same. They felt strongly about the absolute moral prohibition against euthanasia. For them, life is has intrinsic and absolute value, an end in itself. Thus, the one Moral principle that is without exception is not to kill.

(a) Even passive euthanasia is wrong from an ethical standpoint. According to these Soviets, if a person comes to a physician, everything should be done. He or she has come for the physician's advice and *unconsciously wants to be treated, even if not treatment were requested.* Use should be sustained until there is full confirmation of death from a physiological point of view.[9]

(b) Numerous anecdotes were related about patients who had not wanted to be treated, who were, nevertheless, treated successfully. One patient, for example, was saved after 40 resuscitation attempts. A well-known person with Parkinson's disease who, over a 3-year period, repeatedly asked to be allowed to die, remained mentally coherent. The family objected to halting treatment, and his life was maintained. As a result, he was able to dictate important scholarly contributions.[11] These writings, to the Soviet mind, provided justification for keeping him alive, despite the patient’s debilitating pain.

(2) Culturally based ethics. Why should Soviet and Dutch ethical positions on euthanasia be so opposite? It is because ethics is culturally based. Events unique to Soviet history helped shape the strongly pro-life stance. The 1922 Penal Code of the Russian Federation, which permitted the mercy killing of patients, was abolished after only 6 months. In addition, the Soviet experience of the war with Nazi Germany was much more immediate than that of the Dutch, and the Soviet remembrances of it are much more acute. Systematic extermination under Stalin is another important part of

the Soviet legacy. *Glasnost* and *perestroika* have also encouraged a more vivid awareness and disclosure of Soviet history. So, the war and the increased awareness and acknowledgement of abuses in Soviet history intensify the fear of future abuses.[12] There is a concern that the weak, old, and dying could again be treated as expendable. This approach to human life (as highly expendable) is stringently avoided if the value of life is held to be infinite.

2-4. ETHICAL VALUES CAN CHANGE OVER TIME

a. **Changing Views on Euthanasia in the United States.** Henk Rigter, Executive Director of the Health Council of the Netherlands says, "Five years ago, [1984] every established medical organization in the world condemned the Netherlands for our stand on euthanasia--our *Nazi policies*, and they called them. Today Britain, Canada, the United States, and others are talking seriously about whether the need exists for it in their own medical systems..."[13]

b. **Changing Views on the Right to Privacy**. An example from the world of journalistic ethics will show how ethics can evolve. Years ago, journalists did not expose the private lives of public officials. It was considered unethical to pry into their private lives. Therefore, in the '60s, President Kennedy's womanizing was kept out of the press. Now, with the publication of biographies and articles on the subject, we learn that Kennedy had numerous romantic liaisons during his White House years. (This information is documented in Federal Bureau of Investigations (FBI) records of his whereabouts, kept as part of standard security procedures.) [14]

(1) If this behavior had come out in the '60s, it would have seriously damaged President Kennedy's political career. But the prevailing ethic at that time was that the morality of the public figure and the private individual were separate, and that public figures had a right to privacy.

(2) Compare this with today's prevailing ethic. Journalists now have a field day exposing the personal misconduct of public figures. Why? It is because Americans now believe that the private figure and the public figure cannot be judged independently from one another, that one's unethical behavior in private life will inevitably contaminate the conduct of one's public business.

2-5. PERSONAL ETHICS CAN AFFECT PROFESSIONAL OR SOCIETAL ETHICS OVER TIME

a. **The Debate Over the "Debbie Letter**." If you ask physicians informally in the US, you will find that some hold euthanasia to be justified, in certain cases. In January 1988, *The Journal of the American Medical Association* printed its now notorious letter, "It's Over Debbie." In it, an anonymous physician-in-training claims to have given a lethal injection of morphine to a 20-year-old woman dying of ovarian

cancer, a woman he had never met before. The physician wrote that the patient's somewhat vague request consisted of one sentence: "Let's get this over with." This triggered a barrage of indignant letters from the nation's anti-euthanasia physicians, opening the subject up for discussion. In the March 1988 issue of *The New England Journal of Medicine,* ten prominent physicians acknowledged that many of their colleagues were already giving their patients the means with which to end their lives. "It is not immoral for a physician to assist in the rational suicide of a terminally ill person," they wrote. "Active euthanasia," they cautiously added, "is something we should be talking about." It is clear from this discussion that ethics is neither static nor black and white.

b. **Changing Values, Beliefs, and Attitudes.** Ethics not only varies by nationality, age group, race, sex, and even family of origin, but it may also be subject to change over time. In addition, personal ethics may be in conflict with professional ethics (as in the case of those physicians currently practicing euthanasia). Why should ethical standards vary so much? Because they are colored by the values, beliefs, and attitudes of the individuals and/or groups concerned and by the pendulum swings of the times. The letters to *The New England Journal of Medicine* point up a shift in attitude within the medical community. This shift is away from an *absolute view* of the moral requirement to preserve life, any life, no matter what the quality of that life.

c. **Using, Testing, and Reformulating a Code of Ethics.**

(1) The professional code of ethics is a document written by people, practitioners in the field. They are people, first; practitioners, second. At the outset of their careers, individuals tend to follow their professional code without question. But, as they gain experience, and come up against situations that test the code, people start to weigh established principles against their own personal ethics. They then turn to colleagues to share experiences and compare reactions.

(2) At some point, a more formal dialogue may then be opened up, leading to an eventual change in the professional code itself. This is not something that happens quickly. (It is not unusual for a professional code to remain unchanged for 5 to 10 years.) Nor, is it suggested that radiographers should feel free to depart from the established norms of their professional code. Principle 5 of the code advocates the exercise of "care, discretion and judgement."

2-6. VARYING ETHICAL VALUES AFFECT THE PRACTICE OF MEDICINE IN DIFFERENT LOCALES

a. **Culturally Based Health Care.** In the first lesson, a distinction was made between the technical aspects of your job for which there is a right and a wrong way of doing things, and the *art* of providing health care for which the answers are less clear-cut. But even this distinction is not so hard and fast. Seemingly objective technical care and treatment decisions are also affected by the prevailing cultural biases (values). Lynn Payer, an American who spent 8 years as a medical journalist in Europe, outlines these differences: "...the way doctors deal with patients and their ailments is largely *determined by attitudes acquired from their national heritage* (emphasis added). The practice of medicine, finally, is an art. And like painting and sculpture, it reflects the culture from which it comes."[16]

b. **Medicine in the United States.** American medicine is imbued with the aggressive, "can do" attitude of the frontier. American physicians order more diagnostic tests than most of their counterparts in Europe, prescribe drugs frequently and in relatively high doses, and seem to resort to surgery whenever possible.

(1) American women are much more likely to deliver their infants by Caesarean section, and undergo routine hysterectomies and radical mastectomies while still in their 40's. The body is viewed as a machine by both patient and physician. Thus like a car, it needs annual checkups and devices like the artificial heart. We perceive death and disease as the enemy to be "conquered."

(2) Antibiotics are frequently prescribed in large doses, for even minor infections. Patients are expected to be aggressive. Patients who submit to drastic treatments in order to "beat" cancer are more highly regarded than patients who resign themselves to the disease.[17]

c. **Medicine In Great Britain.** British medicine is low-key by comparison. English physicians don't believe in routine physical exams, rarely prescribe drugs, and order only half as many x-rays as their American counterparts. The British patient is only one-sixth as likely to have coronary-bypass surgery and will probably never have a CAT (computerized axial tomography) scan. This economy of practice is due, in part, to the fact that medicine is socialized (funded by the National Health Service). British physicians have always been conservative. Contrary to the American tendency to do everything possible, British medical practice reflects the philosophy, "when in doubt, don't treat." The British attitude of maintaining a "stiff upper lip" is also reflected in medical attitudes. Psychiatrists, for example, tend to regard people that are quiet and withdrawn as normal, while quickly prescribing tranquilizers to anyone who seems unsuitably overactive.

d. **Medicine in France**. French physicians routinely prescribe the yogurt derivative *Lactobacmus* along with antibiotics to prevent stomach upsets that sometimes occur from those drugs, though there is no proof that *Lactobacmus* actually helps normalize the intestinal tract; therefore, more importance is attached to the *theory* underlying a treatment than any experimental evidence.

(1) The French people are extremely sensitive to preserving the beauty and integrity of the human body. Thus, breast cancer is more likely to be treated by radiotherapy than by surgery. There is respect for a woman's childbearing ability that translates to less frequent hysterectomies, performed only for cancers and other serious illnesses.

(2) The French people believe that the patient's constitution, or *terrain,* is an important factor in disease. Thus, they emphasize the use of tonics and vitamins to bolster the terrain more often than they prescribe antibiotics to fight germs. By contrast, American physicians tend to emphasize the role of external agents, including bacteria, as causes of disease.[20]

e. **Medicine in Germany**. In Germany, medicine is a mix of romanticism which may, at times, put emotion ahead of thought and 20th-century technology. There are more physicians per capita than in other European countries, and a German sees his or her physician an average of 12 times a year, compared with 4.7 times in the US. Additionally, over 120,000 drugs are on the market. Doctors make liberal use of electrocardiograms, CAT scans, and other devices. The romantic side of German medicine is revealed by the emphasis physicians place on the heart. A mild cardiac disorder known as *Herzinsuffzienz* is frequently diagnosed. Virtually unrecognized by most physicians anywhere else, German physicians prescribe low doses of digitalis to prevent full-blown heart failure from this disorder.[21]

2-7. ETHICS IS NOT LAW

As stated earlier, ethical theory establishes ideals of behavior that we try, to the best of our abilities, to apply to real-life situations. When faced with a choice between self-interest and a moral imperative, it may be relatively easy, in many cases, to make a moral choice. It may, however, be a hard choice, as in choosing to take in an ailing parent and assuming the role of primary caretaker, but, it is a *clear* choice. Sometimes, however, we are confronted with *moral dilemmas,* situations in which we must choose between *conflicting moral principles.*

> **moral dilemma:** a no-win situation in which the choice is between conflicting moral principles of equal importance.

a. When Jean Valjean, a character in *Les Miserable,* steals a loaf of bread for his starving family, he faces just such a moral dilemma. Survival versus the general good is at stake. The law punishes him for his act with life imprisonment. This is a no-win situation in which choosing act "A" will result in the violation of principle "B", and choosing act "B" will violate principle "A". Some would argue that Valjean's situation is one in which one moral principle (the general good/the moral injunction against theft, especially in times of scarcity).

b. Others would argue that some moral principles are unconditional and not subject to negotiation (that petty theft in time of famine is a serious transgression, even if a starving family is at issue). In any case, ethical dilemmas may often be turned over to the courts to resolve. This doesn't mean, however, that ethical standards are law (though ethics is an important underpinning of the law).

c. Often, ethical choices are weighed on the scales of justice. The courts are, however, not necessarily better equipped to handle moral dilemmas. In a feature article on the role of the courts in resolving ethical dilemmas like euthanasia and abortion, the following observation was made: "Cases that tell people how to live their private lives arouse passionate controversy and are correspondingly difficult to settle."[24] Split decisions often point up the difficulty of making ethical choices, even for the courts.

2-8. ETHICS, THE MOVEMENT OF THE NINETIES?

Michael Josephson, Law Professor and Founder of the Los Angeles-based Joseph and Edna Josephson Institute of Ethics (named for his parents), predicts, "The ethics movement will be to the '90s what the consumer movement was to the '60s."[25] Josephson's phones keep ringing off the lines as he receives more and more requests for his ethics seminars from such diverse groups as the New York State Bar Association, Levi Strauss & Co., Girl Scouts of the USA, and the Internal Revenue Service. A former law professor at Loyola Marymount University in Los Angeles, he specializes in teaching ethics courses to Government officials, business people, and ordinary citizens. His classes are heated and inspiring as he helps his students see the "increasing distance between society's emphasis on measures designed to prevent bad conduct and its incentives to promote good behavior."[26] He tries to teach his students that ethical values are more than a series of rules, that one must look beyond the letter of the law when considering such principles as justice, fairness, and honesty, and that personal values are an important starting point for all other values.[27] (Perhaps this is the reason why he named his ethics institute for his parents.)

a. Josephson got involved in the teaching of ethics in 1976 when he was asked to teach a course on legal ethics in response to the Watergate scandal. Since 1987, when he founded his ethics institute, he has taught thousands of people in hundreds of companies and organizations. One of his basic principles reinforces the notion, stated earlier, that values (to be values) must be *practiced:* "We judge ourselves by our best intentions, but we are judged by our last worst act."[28]

b. Josephson specializes in the subject of public corruption and how to avoid it, dramatic instances of ethics gone awry (such as the savings and loan debacle of 1990), the police brutality scandal in Los Angeles in which a private citizen videotaped a police beating (1991), statehouse wrongdoing, or corporate misconduct. Whenever there is such a scandal, he gets more requests for help. In his classes, he asks participants to act out real situations they have experienced that involved moral dilemmas. Josephson believes that eventually every leading business and government organization will have an ethics education program.

PATIENT'S RIGHTS VS PUBLIC INTEREST IN SAFETY FROM VIOLENT ASSAULT

Does psychiatrist protect confidentiality of patient disclosure (intent to murder)?

OR

Does psychiatrist protect life of intended victim and compromise patient confidentiality?

Figure 2-3. Moral dilemma

Section II: THE ETHICS OF CARING: RESPONDING TO PATIENT MOOD SWINGS

2-9. YOUR CLINICAL RESPONSIBILITIES TO THE PATIENT

In the first section of this lesson, we saw how values, beliefs, and attitudes affect our ideas of right and wrong, good and bad, desirable and undesirable. These same values, beliefs, and attitudes also affect the patient's tolerance of the hospital stay. You, as a health care professional, must be aware of common feelings that affect patients. Such awareness will help you perform the caring aspect of your job more effectively. By dealing better with the mood swings of your patients, it will also indirectly allow you to perform the technology aspect (positioning the patient, preparing him for injections, etc.) more efficiently. It will allow you to anticipate and to recognize patient behaviors for what they are.

2-10. DEPENDENCY

The caring aspect of your job involves being friendly, cheerful, and sympathetic to patients. A patient with whom you are not assigned to interact repeatedly asks you for help, in the course of his stay. One day you direct him to the lab; the next day you accompany him to the sitz bath. The day after, he asks you to take him to the dental clinic. When does being helpful and compassionate lead to unacceptable infringements on your time and ability to accomplish your main duties? You must be on guard against increasing and unnecessary attachments of this kind. It is your job to draw the line between a friendly and supportive stance and an intolerable encroachment. There is a point at which the patient's dependency can seriously affect your ability to do your job, and the patient's ability to make a speedy recovery.

a. It is normal for the patient to feel dependent. To a large extent, the patient is no longer self-sufficient and must legitimately seek the help of others, having involuntarily given up much personal control over simple everyday functions, such as going to the bathroom, eating, taking a shower, and so forth.

b. Because of these inevitable losses of control, the patient may be inclined to abdicate all control. In some cases, although the patient finds it difficult to be dependent upon others, he or she may enjoy the advantages of being cared for and the relief from responsibilities. In more extreme cases, the patient may react to this state of dependency by exhibiting diminished self-respect and a fear that people will no longer accept him or her as an adult. By discouraging unnecessary dependency, you are helping the patient along the road to recovery and, at the same time, protecting yourself from being taken advantage of.

2-11. STRANGENESS

It is not surprising that a patient should feel strange in an unfamiliar and often bewildering hospital environment. Isolated from the security of normal surroundings and the support system of friends, family, and work associates, the patient may legitimately experience a sense of strangeness when confronted with unfamiliar, embarrassing, and/or painful procedures. Who wouldn't feel strange and alone when placed in an overpowering CAT scan? It is important for you to keep this in mind, so that you do everything to ease this feeling of strangeness, and certainly nothing that would aggravate it. It is, for example, poor practice and unethical to prepare an extremely cold barium enema. The patient could die of shock from the excessive coldness. Take pains to make procedures that are inherently strange as tolerable as possible.

2-12. FEAR

A patient may be fearful for a number of reasons to include a fear of: the illness itself, treatment or surgery, the pain and discomfort, the possibility of a long recovery, permanent damage, or death. One's sense of fear is also influenced by the values, beliefs, and attitudes of family and friends, and the impact of the illness on one's work status. You must be compassionate, doing everything within your power to allay these fears.

2-13. IRRITABILITY

A patient may become upset over minor matters. He or she may be restless and impatient, provoked over the slightest interruption or discomfort. (This is especially true of the elderly.) All of the feelings discussed earlier contribute to a lowered tolerance level (higher irritability) that you must deal with even-temperedly. There is no control if an irritable patient is confronted with an equally irritable health care professional. A first-hand account of the consequences of health care provider irritability involves the case of a Basic Medical Specialist (91B10) working in Korea. Pushed over the limits by

a patient's irritability and seemingly limitless demands, the medic threw an addressograph machine at the patient. Such behavior is unprofessional (poor practice), unethical, and a criminal act of assault. It does not contribute to the recovery of the patient. It may even present legal risks for the health care provider and the hospital.

2-14. CONCERN OVER BODILY SENSATIONS

A patient may become overly concerned about normal feelings and sensations that are typically not noticed when one is in good health. Treat the patient with respect, listen earnestly, and attend to his or her complaints. But also remind the patient that it is quite common to become overly concerned with one's bodily sensations when hospitalized.

2-15. SUGGESTIBILITY

All of the factors described above (dependency, strangeness, fear, irritability, and excessive concern over bodily feelings) contribute to a heightened suggestibility. Suggestibility is a tendency to be overly influenced by one's environment. For example, a patient hears the complaints and symptoms of other patients. She begins to wonder if she might have some of the same symptoms, and may even begin to believe that she is actually experiencing those symptoms.

2-16. LOSS OF INTEREST IN SURROUNDINGS

A patient may become so totally absorbed in his or her illness that everything else loses importance. Friends, family, job, and goals are forgotten. You can help to steer the patient away from an unproductive single-mindedness about the illness by regularly referring to the patient's larger framework of friends, family, job, and goals.

2-17. FRUSTRATION

a. Frustration, a condition of increased emotional tension, can be the result of any one of several factors, such as failure to realize sought out gratifications or thwarted interests or values. The wrong lunch menu can inspire feelings of frustration in a patient who has little else for which to look forward. If the patient is used to commanding respect and attention in the outside world, inadequate contact time with the physician to discuss the illness can result in frustration. And if you are the next health care professional that the patient encounters, you may end up bearing the brunt of that frustration.

b. The most common result of frustration is hostility and anger. What you can do for the patient is not to take it personally when he or she vents these feelings. By understanding that a patient is easy prey to frustration, by being tolerant of an outburst without being affected, you have allowed the patient a therapeutic release that helps him or her to go on without feeling overcome by events.

2-18. BEHAVIORAL RESPONSES OF THE PATIENT

a. **General.** A patient's negative feelings can result in counterproductive, behavioral responses to illness and hospitalization. The patient's attitude, feelings and behavior are a response not only to what is done in terms of care and treatment, but how it is done. Thus, the attitude and behavior of the x-ray technologist (and all other health care providers with whom the patient comes in contact) will have considerable impact on the patient's attitude and behavior. Your attitude and behavior contribute to the patient's environment, which can influence a patient's response to treatment. So the manner in which you respond not only affects the patient's mental well being, but his or her physical recuperation as well.

b. **Aggression.** Aggression, the most common response to frustration, can range from sarcastic remarks to destructive behavior. The patient may talk back, resist directions or treatment, brag, chronically complain, find fault with others, delight in intentionally causing inconveniences, fight with other patients and staff, or simply not cooperate.

c. **Avoidance.** Avoidance, physically or mentally leaving a situation, is a common response to loss of interest in one's surroundings. But it may also be the result of a sense of strangeness or fear. While this kind of patient may not be a visible nuisance like the aggressive patient, the feelings that generate avoidance are harder to defuse. The aggressive patient's feelings are released by aggressive behavior. By comparison, it is harder to get at the feelings of a patient who practices avoidance.

d. **Resignation.** The patient who is resigned has given up and approaches everything passively. The resigned patient is hard to deal with because he or she discourages any action that might lead to a solution.

e. **Withdrawal.** The patient who is withdrawn feels unable to cope, retreating into a shell to avoid unpleasant situations. This type of patient lacks interest in normal activities of daily life or in recovery, becomes uncommunicative, and loses self-confidence.

f. **Regression**. The patient who has regressed exhibits the most counterproductive behavior of all reverting to childlike behavior and immature attitudes; this kind of patient does not wish to regain independence and responsibility. Fearing and suspecting change and new ways of doing things, this patient seeks frequent reassurance and repeated explanations. Use a child, he or she demands immediate satisfaction for his needs, while displaying little regard for others.

2-19. APPROPRIATE BEHAVIOR FOR A HEALTH CARE WORKER

a. **Be cheerful**. Smiling goes a long way toward reducing patient anxiety and tensions.

b. **Be sympathetic and understanding**. Listen to the patient; show you care about his or her concerns. Accept the patient as an individual rather than as an object. It is easy to fall into the trap of treating the patient like an object, especially if the patient is remote or withdrawn.

c. **Keep the patient informed**. This will lessen apprehensions and increase the likelihood of cooperation.

d. **Be courteous**. That may seem too obvious, but treating the patient with respect drives home the message that the patient is an individual worthy of respect, even if he or she is somewhat dependent and is experiencing feelings of strangeness, fear, etc.

e. **Look efficient.** Your personal appearance is important in helping the patient feel positive about the health care environment.

f. **Sound efficient**. Take care not to say anything compromising or negative in the patient's presence. Avoid saying things that are not reassuring because the patient needs all the reassurance he or she can get.

Continue with Exercises

EXERCISES, LESSON 2

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response(s) that best answer(s) the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. Views on ethical questions such as euthanasia will vary from country to country because values are:

   a. Largely universal.

   b. Permanent and unchanging.

   c. Culturally based.

   d. For the most part, an individual matter.

2. A/an _____ is a decision to choose one end-state of existence (for example, an old age without excessive pain) over another end-state.

   a. Instrumental value.

   b. Terminal value.

   c. Personal philosophy.

   d. Moral imperative.

3. Honesty, cooperation, self-control, and efficiency are examples of:

   a. Instrumental values.

   b. Terminal values.

   c. Beliefs.

   d. Attitudes.

4. An individual's personal philosophy or orientation to life is determined by his or her own personal values, beliefs, and:

   a. Attitudes.

   b. Action-guides.

   c. Destiny.

   d. Educational level.

5. Which of the following terminal values would be associated with the decision to draw up a living will?

   a. The sanctity of all life.

   b. The quality of life.

   c. Death and disease as the enemy to be "conquered."

   d. The equality of all people.

6. The most important characteristic of a belief is that:

   a. It is, in fact, true.

   b. It can be verified by others.

   c. The believer considers it to be true, even if it may have been disproved.

   d. It is objectives.

7. Within the same society, views on such controversial ethical issues as the right to life will vary from person to person. The reason for this variation is that the formulation of one's values is affected not only by nationality, but by race, religion, sex, family, and _____, to name only a limited number of factors.

   a. Age group.

   b. Diet.

   c. Health insurance coverage.

   d. Blood type.

8. Which of the following generally characteristics the practice of medicine in the United States?

   a. An acceptance of the limits of technology.

   b. A great respect for the aesthetics of the human body.

   c. A "can-do" attitude, death, and disease as an enemy to be conquered.

   d. Conservativeness in running tests and prescribing medicine.

9. In a moral dilemma, one is faced with a choice between:

   a. Self-interest and the moral imperative.

   b. A higher and a lesser moral principle.

   c. Evolving moral principles.

   d. Conflicting moral imperatives of equal importance.

10. A mental patient confides his intention to commit murder to his psychiatrist. Though attempts to have the patient committed fail, the psychiatrist does not alert the intended victim. This is an example of a _____, in which upholding the patient's right to confidentiality leads to the violation of the public's right to safety from violent action.

    a. Morally difficult choice.

    b. Moral dilemma.

    c. Win-win situation.

    d. Crime.

11. Martha Henry decides to go to medical school, sacrificing her social life and other interests to attend class, study, and get the grades that will ensure academic success and a medical degree. Her goal direction, ambition, and hard-working nature are the modes of conduct or _____ that will ensure success.

    a. Terminal values.

    b. Instrumental values.

    c. Beliefs.

    d. Attitudes.

12. In the preceding situation (exercise 11), academic success wins out over a busy social life and time for hobbies as Martha's:

    a. Terminal value.

    b. Instrumental value.

    c. Belief.

    d. Attitude.

13. Over the years, Jean has heard various family members recount favorable stories about labor unions. The union recently helped Jean and his workmates negotiate better working conditions. As a result, Jean has a positive _____ toward labor unions.

    a. Belief.

    b. Attitude.

    c. Conviction.

    d. Value.

14. The caring component of your job as a health care provider involves anticipating and _____ feelings commonly experienced by patients.

    a. Tolerating.

    b. Hiding your reactions to.

    c. Responding appropriately to.

    d. Blocking your reactions to.

15. An outpatient asks you for directions to the pharmacy which you cheerfully provide. The next day, he asks you for directions to the sitz bath. Once you have provided these directions, he then asks you to accompany him. This patient is exhibiting feelings of _____ that will undermine his already diminished sense of self-respect.

    a. Dependency.

    b. Suggestibility.

    c. Strangeness.

    d. Frustration.

16. It is understandable that a patient should experience fear and _____ at the prospect of a CAT scan.

    a. Resignation.

    b. Strangeness.

    c. Loss of interest in surroundings.

    d. Suggestibility.

17. A patient who responds to the hospital stay by reverting to childlike behavior is:

    a. Acting aggressively.

    b. Demonstrating avoidance behaviors.

    c. Withdrawing.

    d. Regressing.

18. A patient who retreats into a shell to avoid unpleasant aspects of the hospital stay is:

    a. Resigned.

    b. Withdrawn.

    c. Aggressive.

    d. A visible nuisance.

19. By being cheerful, courteous, neat in appearance, positive in attitude, and _____, you can do much to counteract the negative feelings and behaviors of the patient.

    a. Allowing the patient to become dependent.

    b. Leaving the patient alone.

    c. Treating the patient as an individual, not as an object.

    d. Encouraging the patient's negative tendencies.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2

1. c (paras 2-3a(3) & 2-6a))
2. b (para 2-2b)
3. a (para 2-2b)
4. a (para 2-2a)
5. b (figure 2-1)
6. c (para 2-2c)
7. a (para 2-3, para title)
8. c (para 2-6b)
9. d (para 2-7)
10. b (para 2-8, figure3)
11. b (para 2-2b)
12. a (para 2-2b)
13. b (para 2-2d)
14. c (para 2-8)
15. a (para 2-9)
16. b (para 2-10)
17. d (para 2-17e)
18. b (para 2-17d)
19. c (para 2-18)

NOTES:

1. Frank A. Chervenak, M.D. and Laurence B. McCullough, Ph. D., "Ethics in Obstetric Ultrasound," Journal of Ultrasound Medicine, Vol. 8, No. 9, p 493, September 1989.

2. Michael Bargo, Jr., Choices and Decisions: A Guidebook for Constructing Values, University Associates, Chicago, 1979, p 38.

3. Ibid.

4. Ibid., pp 38-39.

5. Patrick Cooke, "The Gentle Death," Hippocrates, September-October 1989, pp 50-53.

6. Ibid, p 51.

7. Ibid.

8. Ibid., p 53.

9. Robert M. Veatch, "Medical Ethics in the Soviet Union," The Hastings Center Reports, March-April 1989, pp 11-13.

10. "The Right to Pull the Plug," San Antonio Express-News, July 20, 1990, p 6-B.

11. Veatch, pp 11-13.

12. Ibid., p 13.

13. Cooke, p 52.

14. C. David Heyman, A Woman Named Jackie, Carol Communications, New York, 1989, pp 364-376 and 651.

15. Cooke, pp 56-57.

16. Matt Clark, "The Cultures of Medicine: Why Doctors and Treatments Differ the World Over," Time Magazine, March 19, 1990, p 40.

17. Payer, pp 124-152.

18. Marilyn vs. Savant, "Ask Marilyn," San Antonio Light, August 5, 1990, p 14.

19. Payer, pp 101-123.

20. Ibid., pp 35-73.

21. Ibid., pp 74-100.

22. Ibid., book jacket.

23. Dick Thompson, “Sound Every Baby Be Saved?” Time Magazine, June 11, 1990, p 40.

24. Nancy Gibbs, “Love and Let Die,” Time Magazine, March 19, 1990, p 62.

25. Emily Mitchell, “Brushing Up on Right and Wrong.” Time Magazine, April 15, 1991, p 63.

26. Ibid.

27. Ibid.

28. Ibid.

End of Lesson 2

LESSON ASSIGNMENT

LESSON 3	Legal Considerations.
LESSON ASSIGNMENT	Paragraphs 3-1 through 3-9
LESSON OBJECTIVES	After completing this lesson, you should be able to:
	3-1. Identify three basic sources of the law:
	3-2. Identify the nature of the law.
	3-3. Identify differences between public and private law.
SUGGESTION	After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

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LESSON 3

Section I. THE SOURCES OF THE LAW

3-1. INTRODUCTION

a. **A Lawsuit in the Making**. A 40-year-old man who has been in an auto accident is brought to a hospital emergency room by his wife. His only injuries are some deep lacerations to the face. Since there are no plastic surgeons attached to the hospital, the attending physician recommends that the patient be transferred immediately to a nearby hospital that has plastic surgeons on staff. The attending physician explains that in view of the deep lacerations it is preferable to have surgery done by a specialist rather than by a general surgeon.

(1) The patient's wife wants to drive her husband to the other hospital herself. But, the physician advises her that it would be more prudent to have the patient transported by ambulance in case there is a need for immediate care. The physician explains that with facial lacerations, there might be internal bleeding of the head, which could cause the patient to go into shock and need oxygen or cardio-pulmonary resuscitation. The patient while being transported by ambulance ends up in a serious collision that leaves him a paraplegic. The family sues both the hospital and the attending physician.

(2) The physician followed the tenets of the professional code, making technically sound choices (the technology) and providing the best care possible (the caring). She handled the patient promptly in an emergency situation, obtained consent for transfer to another facility, and explained the rationale for her actions (patient rights and good practice). She was, in summary, behaving according to the prescribed tenets of good practice, applying technical skill in an ethical and a caring manner and respecting the patient's rights. And, yet, her actions could still have legal repercussions for both herself and the hospital. As it turned out, the case was dismissed because there was no legal infraction. But the litigation leading to dismissal of the case was costly, costly in terms of time, money, and emotional wear and tear for all involved.

b. **Malpractice Suits Against Health Providers and/or the Hospital**. Every decision you make, every action you take as a health care professional is affected by legal principles and may have legal repercussions, whether or not you, as a radiographer, are sued directly. (Civilian radiographers are required to have lawsuit insurance in some states and can be sued directly.) What you do as a member of the health care team can have legal repercussions for both the other members of the team and the hospital at large. Since it is impractical to obtain legal advice before each decision you make, it makes sense for all health care providers to develop an awareness of the law. By so doing, you will know how to make decisions that are consistent with the spirit of legal decisions. You will then know which situations warrant legal counsel.

c. **Hospital-Initiated Suits**. *Patient-initiated* lawsuits against hospitals, physicians, and nurses for alleged harm suffered through wrongful conduct get the most publicity. But, *hospital-initiated* lawsuits also come before the courts. Hospitals go to court to challenge decisions by governmental agencies and departments, such as the Department of Health and Human Services, which administers much of the law pertaining to hospitals. (Other departments also affect various other aspects of hospital affairs. The Department of Labor enforces the laws relating to wages and hours of employment, for example.) Hospitals also resort to courts to have legislation concerning hospitals declared invalid, to collect unpaid hospital bills, and to enforce contracts. While litigation brought by patients or government gets the most publicity; very often, it is the hospital that initiates a suit to enforce a right or to protect a legally recognized interest.

d. **Lesson Scope**. This lesson will give you a general idea about the nature and sources of the law and the way in which the law ties into ethics.

BIOETHICAL/LEGAL ISSUES IN THE NEWS

QUALITY OF LIFE

Medical ethicists and physicians question the wisdom of the Baby Doe laws, requiring maximal, life-prolonging treatment of severely handicapped, premature infants. No guidance exists on when to stop treatment that can save lives. The lack of guidance presents a problem. The very treatment that can save lives can, at the same time, cause serious lifelong problems (handicaps such as blindness, cerebral palsy, and other neurological disorders). In Europe, public health policy provides such guidelines.[2]

FETAL RIGHTS

After failed attempts to locate a bone marrow donor for their 17-year-old daughter suffering from leukemia, a Los Angeles couple purposely conceived a child to serve as a donor. (While it has been done before, this is the first time that the parents chose to speak openly about it.) The ethical concern here is protecting the rights of the fetus. What it tests revealed the baby was not a suitable donor? What if the parents aborted the fetus in order to retry? Should an outside legal guardian serve as an advocate for the infant in such cases? The infant, in this case, turned out to be a suitable donor.[3]

(Continued)

BIOETHICAL/LEGAL ISSUES IN THE NEWS
(Concluded)

FETAL RIGHTS IN RESEARCH

In a similar vein, fetal tissue transplants may become effective in treating diabetes, Parkinson's disease, leukemia, and quadriplegia. The University of Minnesota Center for Bioethics reported on the findings of 25 scientists and ethicists who met on the issue for nearly 2 years. The report concludes that, without suitable controls and definitions, babies could be conceived, and then aborted as medicine for others. If fetal tissue is part of the mother, she could give prior permission for its use. If the fetus is a dead individual, permission must be obtained from close relatives.[4]

RIGHT TO DIE

The Supreme Court ruled that a patient's wish to terminate life-sustaining care should be honored, provided clear supporting evidence, for example, a living will, existed. The Court initially denied Nancy Cruzan's parents the right to terminate life support after an auto accident that left her in a coma for years for lack of such supporting evidence.[5]

RIGHT TO TREATMENT/LIFE

Tom Bradley, a 46-year-old AIDS patient, took The Empire Blue Cross and Blue Shield Insurance Company to court for refusing to pay for a bone marrow transplant that could prolong his life. The Manhattan State Supreme Court ruled in his favor.[6]

FETAL RIGHTS

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AUTONOMY

The Supreme Court limited the autonomous decision making of pregnant teenagers by ruling that states may require the girl to notify her parents or to get a judge's permission before she an abortion .[7]

CHILD'S RIGHT TO TREATMENT VS. RELIGIOUS FREEDOM

A Christian Scientist couple, David and Ginger Twitchell, shunned medical treatment for their ailing toddler who died of bowl obstruction They were convicted of manslaughter.[8]

3-2. THREE BASIC SOURCES OF THE LAW

Three sources of the law are: statutes, decisions, and rules of administrative agencies, and court decisions. (The fourth source of the law, the Constitution, will not be considered here.)

3-3. STATUTES, A BASIC SOURCE OF THE LAW

a. Statutory law, enacted by various legislatures, is a basic source of the law. Legislative bodies that enact statutes include the US Congress, state legislatures, city councils, and county boards of supervisors.

b. When there is a conflict between Federal and state laws, valid Federal law takes precedent. In conflicts between state and local laws, valid state law prevails.

> **statutory law**: a body of written laws originating in Federal, state, and local legislatures.

3-4. DECISIONS AND RULES OF ADMINISTRATIVE AGENCIES

a. **Administrative Agencies Empowered by the Legislature**. Decisions and rules of Federal and state administrative agencies are another basic source of the law. Many administrative agencies are given the responsibility and power to adopt regulations and to decide how statutes and regulations apply to individual situations. Administrative agencies, such as the Food and Drug Administration (FDA), the Environmental Protection Agency (EPA), the National Labor Relations Board (NLRB), and the Internal Revenue Service (IRS), are given these powers because the legislature does not have the time or the expertise to address the complex issues involved in many areas that need to be regulated. Radiation protection requirements for lead in the walls surrounding x-ray machines and the monitoring of x-ray machines for leakages are the result of FDA rules and regulations.

> **decisions and rules**: mandates and decisions from Federal and state administrative agencies, for example, EPA, FDA, IRS.

b. **Agencies' Decisions Based on Past Precedent**. In order to be consistent in their decision making, agencies look back at the position they adopted in previous cases involving similar matters. This is comparable to the way in which courts develop common law (see paragraph 3-5). When dealing with agencies, it is important to review the body of laws that has evolved from their previous decisions. Generally, proposed rules must be published to allow comment before they are finalized. Professional or hospital associations fulfill an important role by monitoring and commenting on

proposed and final rules. This is important because administrative agencies do not always realize the implications of their proposals. They rely on the public and those agencies that come under their regulatory guidance to alert them to possible problems through the feedback process.

3-5. COMMON LAW, ANOTHER BASIC SOURCE OF THE LAW

a. **Court Decisions Resolving Specific Controversies**. Yet another basic source of the law is common law, the principles that evolve from court decisions rendered to resolve controversies. Many of the legal principles and rules applied by the courts in the US are the product of common law that was developed in England and later in the US The court's role is to resolve disputes. But in the process of deciding individual cases, the courts interpret statutes and regulations. They determine whether specific statutes and regulations are permitted by state or Federal constitutions. They create common law when deciding cases that are not controlled by statutes, regulations, or the constitution.

> **common law**: a body of laws originating from Federal, state, and local court decisions.

b. **Precedent Usually Followed**. In resolving specific controversies, courts, for the most part, follow precedent. They follow the rules and principles applied in similar, previously decided cases. However, the courts may recognize distinctions between precedent and the current case, or they may conclude that a particular common law rule is no longer in accord with the needs of society (due to changing values or priorities). For example, the longstanding principle of charitable immunity gave nonprofit hospitals virtual freedom from liability for harm to patients resulting from wrongful conduct. This principle, which had been in effect for over 30 years, was eventually overruled by the courts in state after state.

Section II: THE NATURE AND ROLE OF THE LAW

3-6. THE NATURE AND ROLE OF THE LAW

a. **Legal vs Ethical Standards**. Through the law, society specifies standards of behavior and the *means to enforce those standards*. In One L, Scott Turow's inside account of life as a first-year student at Harvard Law School, a law professor warns his student:" in learning rules, don't feel as if you've got to forsake a sense of moral scrutiny. The law in almost all of its phases is a reflection of competing value systems."[9] In this sense, the law seems much like ethics inasmuch as it is a reflection of conflicting societal values.

(1) But the law and ethics vary in the way in which they deal with ambiguity. Ethics can deal with shades of gray, in assessing what is right and wrong. By contrast, "...law is at war with ambiguity, with uncertainty. In the courtroom, the adversary system, plaintiff against defendant, guarantees that someone will always win, someone will lose...Law and the arbitrary certainty of some of its results are no doubt indispensable to the secure operation of a society where there is ceaseless conflict requiring resolution."[10]

(2) There are a number of ways in which the law supports ethics. Ethical standards (ideals of behavior) are, to some extent, reflected in the law. You will recall that the patient's bill of rights outlined a combination of legal and ethical rights that have been codified into the law and are, therefore, enforceable under the law. Ethical *rights* that are not the law can only be *enforced* through the pressure exerted by ethics committees and professional organizations. Ironically enough, the law itself, at times, may seem to undermine the observance of ethical principles.

b. **The Adaptability of the Law**. The ability of the law to adjust is one of its strengths. Legal uncertainty is similar to the uncertainty encountered in making medical and nursing diagnostic and treatment decisions. *When dealing with Systems as complicated as the human body or human society, uncertainty is inevitable.*

Says Scott Turow, practicing attorney and author, “the law [can be seen] as a response to political and social traditions and not something sent from heaven. The law can change; the law can vary from place to place. And in those changes and variations, the law, like any other social product, reflects the persistent conflicts and contradictions within society."[1]

c. **The Law as a Guide and Stimulus to Peaceful Resolution of Disputes**.

(1) Like ethics, the law serves as a guide to conduct daily life. Most disputes or controversies between persons or organizations are resolved without lawyers or courts. *The existence of the legal system is a stimulus to an orderly private resolution of disputes.* A knowledge of the relevant legal principles serves as a reinforcement of compromises reached. The likelihood of success affects the willingness of parties to negotiate private settlements.

(2) Hospital administrations retain medical ethicists and lawyers on their staff for the purpose of obtaining advice on the permissibility of proposed actions. But, lawyers and ethicists cannot be consulted for every move a health provider must make. That is why *knowledge* of the sources of the *law* and their application is *important for anyone involved in providing health care.*

d. **Legal Accountability as a Stimulus to the Proper Practice of Skills**. In addition to the ethical responsibilities health care providers have towards their patients, they also have a legal responsibility to provide the best care possible. When the level of care falls below acceptable standards and injury occurs, the health care professional and health care facility can be held legally accountable. Consider the seemingly routine procedure of taking x-rays. A radiographer will take many x-rays in the course of a career. These procedures should never become so automatic that the x-rays taken are less than first-rate. Sloppy work can have serious effects on the patient's condition, as the following anecdotes illustrate.

(1) The case of the missing anatomical structures. Radiologists commonly use x-rays to diagnose fractures. A failure to include the relevant anatomical structures could have serious medical implications for the patient and legal and ethical implications for the health care team and hospital. Legal action was brought against a hospital for personal injuries resulting from the alleged negligence of the radiographer in taking x-rays of a patient's right leg. The film tailed to include the ankle joint. The attending physician, finding no fracture on the film, treated the patient for a sprained ankle. An x-ray exam, taken 3 months later, revealed that the patient had fractured ankle bones that had united in poor position. The radiographer, as an employee of the hospital, made the institution liable for damages to the patient. And the attending physician, the radiologist, and the hospital were named in the resulting lawsuit.

(2) The case of the mislabeled x-ray. In another instance, an x-ray technologist, employed by a radiologist in private practice, took an x-ray of an infant's lungs, but she got confused on the labeling. She incorrectly marked the left lung with an "R" and the right lung with an "L." As a result, the attending physician made an unnecessary intervention (fluid removal) on the healthy lung and left the problem lung (the one with fluid build-up) untreated, causing the infant to die. In the resulting lawsuit, the radiographer, the radiologist, and the hospital were named.

e. **Enforcing Ethical and Legal Standards**.

(1) Hospital ethics committees routinely evaluate actions taken in the hospital, and thus provide a mechanism for reviewing actions against established ethical and legal standards. (There are certain procedures that they routinely evaluate, e.g., taking someone off a respirator. Other issues are brought before the committee for resolution on a case-by-case basis.)

(2) Professional organizations like the American Medical Association attempt to enforce standards by establishing official positions on controversial issues. For example, in 1989 the AMA came out with a statement saying that doctors do not have the right to refuse treatment to someone who has tested HIV-positive for AIDS. "When an epidemic prevails, a physician must continue his labors without regard to the risk of his own health."[15] On the other hand, of 41,000 physicians polled on this issue, 50 percent believed they *did* have the right to deny care, and 15 percent said they

actually would refuse to provide care.[16] In the final analysis, the uncertainty surrounding such ethical issues remains until the law brings definition to the problem. Positive decisions in test cases set precedent for new laws that can enforce ethical standards.

3-7. THE ROLE OF THE LAW: REGULATING PUBLIC AND PRIVATE RELATIONSHIPS

a. **Overview**. The role of the law is to govern the relationship of private individuals with each other and with government. These two roles correspond to *two general categories of the law: private and public.* However, in fact, many laws have both private and public law aspects. So, it is not possible to neatly classify the laws as such. What is important is to be aware of the two major roles of the law.

b. **Private Law**. Private law deals with the relationship between private individuals and organizations. In private law, an individual brings tort action to protect private interests.

c. **Public Law**. Public law addresses the relationship of individuals with government and governmental agencies. In one aspect of public law, the government brings criminal action to protect society.

private law: a body of laws governing the relationship between private individuals and organizations.

public law: a body of laws governing the relationship between private individuals and government (or governmental agencies) in order to protect society as a whole.

3-8. TYPES OF PUBLIC LAW

a. **The Goal and Thrust of Public Law**. Public law defines, regulates, and enforces the relationships of individuals with government and governmental agencies. The goal of public law at both Federal and state levels is to deal with societal problems of a broad nature. And, though there are criminal penalties for individuals and organizations that do not abide by the regulations, the thrust of public law is to *secure compliance* with and attain the goals of the law, not to punish offenders. If the EPA finds a company discharging chemicals into a public river, a fine will be levied for violating this waterway *until* it is corrected.

b. **Criminal Law**. Criminal law outlaws conduct deemed injurious to public order, and provides for punishing those who have engaged in such behavior. The government brings criminal action to protect society. By punishing and hopefully reforming the offender, it will protect society and deter others from criminal acts.

c. **Regulations Advancing Societal Objectives**. Some regulations are designed to require private individuals and organizations to follow specified courses of action designed to advance societal objectives. Public policy concerning health care, to include health planning, containment of health care costs, quality of clinical laboratory operations, medical device safety, labor relations, employment policies, facility safety, and other important topics, come under this category.

3-9. TYPES OF PRIVATE LAW

a. **Overview**. Private law recognizes and enforces the rights and obligations of private individuals and organizations. It can be divided into two categories: contract law and tort law.

b. **Contract Law**. Contract law involves agreements among private individuals or compensation for failing to fulfill those agreements. Contractual disputes may deal with the sale of merchandise or real estate or the provision of work, labor, or professional services, to name a few examples. Most malpractice suits against health care providers and hospitals are based on tort law, not contract law.

c. **Tort Law**. A tort is a breach of a duty, other than a contractual duty, which gives rise to an action for damages to compensate the injured party. Tort law deals with injury or wrongdoing committed with or without force/intent to the person or property of another. A tort case may involve trespassing upon another's land, committing assault and battery upon a person, creating a nuisance, damage through negligence to the person or property of another, or defamation of character (libel and slander), to name a few examples. Most malpractice suits against physicians and hospitals are based on tort law. The same act may be both a crime against society and a tort against an individual.

> **Tort**: a civil wrongdoing or injury, other than contractual, which gives rise to an action for damages to compensate the injured party.

Continue with Exercises

EXERCISES, LESSON 3

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response(s) that best answer(s) the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. Every decision you make as a health care professional is affected by ethical and _____ considerations that may have _____ repercussions. (Same word, both spaces.)

   a. Legal.

   b. Societal.

   c. Political.

   d. Arbitrary.

2. _____ resort to the courts to have legislation declared invalid, to collect unpaid bills, and to enforce contracts.

   a. Patients.

   b. X-ray technologists.

   c. Orderlies.

   d. Hospitals.

3. A basic source of the law enacted by Congress and state or local legislatures is:

   a. Administrative decisions and rules.

   b. Constitutional law.

   c. Common law.

   d. Statutory law.

4. Administrative agencies, such as the Food and Drug Administration, the Environmental Protection Agency, and the National Labor Relations Board, generate _____, which may affect hospitals.

   a. Decisions and rules.

   b. Common law.

   c. Statutory laws.

   d. Constitutional law.

5. Before an agency such as the EPA can generate new requirements for x-ray machines, it must publish proposed and final rules, so that professional and/or hospital associations can _____ them.

   a. Approve.

   b. Comment on.

   c. Veto.

   d. Annotate.

6. _____ emanate(s) from court decisions resolving specific controversies.

   a. Constitutional law.

   b. Statutory law.

   c. Administrative rules.

   d. Common law.

7. In resolving specific controversies, courts generally follow _____ the rules and principles applied in similar, previously decided cases.

   a. Exceptions.

   b. Common law.

   c. Precedent.

   d. Administrative agency regulations.

8. A knowledge of the sources of the law and their application is important for:

    a. Physicians.

    b. Nurses.

    c. Radiographers.

    d. All health care providers.

9. The law, like medicine, must _____ the requirements of complex and changing realities of human society.

    a. Stand firm on.

    b. Adapt to.

    c. Disregard.

    d. Develop.

10. An x-ray technologist fails to include a fractured ankle in an x-ray of a patient's leg, leading to improper union of the bones and injury. The patient is likely to sue the:

    a. X-ray technologist.

    b. Radiologist.

    c. X-ray technologist and the radiologist.

    d. Attending physician, the radiologist, and the hospital.

11. Public policy concerning health care falls under:

    a. Criminal law.

    b. Private law.

    c. Public law.

    d. Contract law.

12. Contract law deals with:

    a. Agreements among private individuals.

    b. Conduct that may be injurious to the public order.

    c. The relationship between the individual and the government.

    d. The duties and rights of public institutions.

13. Most malpractice lawsuits against health providers and hospitals are based on:

    a. Public law.

    b. Contract law.

    c. Criminal law.

    d. Tort law.

14. Health care policies fall under:

    a. Criminal law.

    b. Private law.

    c. Public law.

    d. Contract law.

15. Damage through negligence falls under:

    a. Contract law.

    b. Tort law.

    c. Criminal law.

    d. Public law.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3

1. a (para 3-1b)
2. d (para 3-1c)
3. d (para 3-3)
4. a (para 3-4a)
5. b (para 3-4b)
6. d (para 3-5a)
7. c (para 3-5b)
8. d (para 3-1b)
9. b (para 3-6b)
10. d (para 3-6d(1))
11. c (para 3-8c)
12. a (para 3-9b)
13. d (para 3-9c)
14. c (para 3-8c)
15. b (para 3-9c)

NOTES:

1. Scott Turow, One L, Penguin Books, New York, 1978, p 197.

2. Dick Thompson, “Should Every Baby be Saved?” Time Magazine, June 11, 1990, pp 40-11.

3. Anastasia Tufexis, “Treating a Child to Save Another,” Time Magazine, June 10, p 56.

4. Scripps Howard Service, “Scientists Debate Ethical Considerations in Use of Fetal Tissue,” San Antonio Express-News, February 18, 1990, p B-4.

5. Los Angeles Time Service, “The Right to Pull the Plug,” San Antonio Express News, July 20, 1990, p B-6.

6. Greg B. Smith, “Many AIDS Patients Fighting Insurance Firms for Payment, “ San Antonio Light, August 5, 1990, p D-1.

7. Katherine Bouton, “Painful Decisions: The Role of the Medical Ethicist," The New York Time Magazine, August 5, 1990, p 65.

8. Ibid.

9. Turow, p 83.

10. Ibid, p 267.

11. Loretta M. Kopelman, Ph.D., et al., “Neonatologists Judge the ‘Baby Doe’ Regulations,” The New England Journal of Medicine, Vol. 318, No. 1, pp 677-683, March 17, 1988.

12. Bouton, p 64.

13. Ibid.

14. Bertram Manuel, M. D., “A Contemporary Physician’s Oath,” Letter to the Editor, The New England Journal of Medicine, Vol. 319, No. 8, p 522, August 25, 1988.

15. Richard Tubro, “when Doctors Say No,” Good Housekeeping, August 1989, p 86.

16. Ibid.

End of Lesson 3

LESSON ASSIGNMENT

LESSON 4	The Legal Ramifications of Your Every Health Care Move.
LESSON ASSIGNMENT	Paragraphs 4-1 through 4-10
LESSON OBJECTIVES	After completing this lesson, you should be able to:

4-1. Identify definitions of intentional and negligent torts.

4-2. Identify examples of intentional and negligent torts.

4-3. Identify the four elements of liability for actionable negligence:

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 4

Section I. TORT LAW AND HEALTH CARE

4-1. INTRODUCTION

a. **A Lawsuit in the Making Revisited**. The last lesson began with the case of an emergency room physician who refers an auto accident victim with deep facial lacerations to another hospital. En route, the patient suffers further serious injuries as a result of the ambulance being involved in a serious collision. The injured party sues the first hospital and the attending physician for negligence. Such an action would fall under tort law, the topic of this lesson. The charges are, ultimately, dropped because the four elements (later mentioned) of actionable negligence cannot be proven.

b. **Lesson Scope**. This lesson covers torts, wrongdoing involving someone else's rights. It describes two types of torts: intentional and negligent (unintentional), the latter being the most common basis for liability of healthcare professionals and hospitals. This lesson also outlines the four elements of actionable negligence that must be proven in order to establish liability: duty owed, breach of duty, injury, and causation. (In the case outlined above, breach of duty could not be established, and, therefore, liability could not be proven.)

> **actionable negligence**: negligence for which legal responsibility (liability) can be assessed.

4-2. TORT LIABILITY

As stated earlier, a tort is a civil wrongdoing or injury, other than contractual, which gives rise to an action for damages to compensate the injured party. In a tort suit, the alleged injured party (claimant or plaintiff) seeks monetary payment (damages). Compensation is sought for harm allegedly done by a defendant or an actor.

a. **Damages**. Damages may be compensatory, that is, designed to make the injured party "whole" to the extent that money can do so.

(1) Damages may also be punitive, that is, set at a level intended to punish the actor and serve as an example to deter others.

(2) Tort cases cover a full range of human mishaps to include: auto wrecks, beatings, medical malpractice and injuries from defective products. A civil tort case might involve a matter as mundane as Mr. Jones' barking dog. His neighbor, Mrs. Klein (the plaintiff or the alleged injured party), takes the defendant, Mr. Jones, to court and sues him for damages.

b. **Fault**. Fault is almost always involved in tort liability cases. Something was done wrong or something that should have been done was not. The wrongful act or the omission may be intentional or unintentional (the result of negligence). (A third type, no-fault [or strict liability) torts will not be covered here.)

claimant (plaintiff): the alleged injured party who seeks damages in a tort suit.

actor (defendant): the party against whom damages are sought for injury in a tort suit.

damages: payment (compensation) for injury in a tort suit.

compensatory damages: payment designed to make the injured party "whole" to the extent that money can do so.

punitive damages: compensation set at a high level in order to punish the actor and serve as an example to deter others.

4-3. INTENTIONAL TORTS

a. **Overview**. An intentional tort arises from the intent to do an act, or bring about a result, which will involve the interests of another in a way the law will not sanction. The intent involved is not necessarily hostile nor need there be any desire to harm someone. Intentional torts include assault and battery, defamation, false imprisonment, invasion of privacy, and the intentional infliction of emotional distress. These will be described below.

b. **Assault and Battery**.

(1) Assault. Assault is an action that plus someone in *fear* of being touched in a way that is insulting, provoking, or physically hurtful without lawful authority or consent. No actual touching is required. Assault is simply the likely threat of inappropriate touching. The act approaching a patient with a needle can be viewed as assault unless you have prepared the patient psychologically.

(2) Battery. If unauthorized touching occurs, it is battery. Assault or battery can occur when medical treatment is attempted or performed without lawful authority or consent. The act of jabbing the patient with a needle without consent would be battery. Getting the patients to turn on his or her side inevitably involves touching. Even routine handling, a seemingly innocent and legitimate component of the job, can be construed as assault under certain conditions. Operating on the left leg when consent was obtained to operate on the right leg is considered battery.

c. **Defamation**. Defamation is injury to another person's reputation. Written defamation is libel; verbal defamation is slander. A patient, for example, may claim defamation if you claim that he or she is a deadbeat who doesn't pay the bills.

d. **False Imprisonment**. False imprisonment is the unlawful *restriction* of someone's freedom. Holding a person against his or her will by physical restraint, barriers, or even threats of harm can constitute false imprisonment, if not legally justified. False imprisonment takes other forms beside the obvious case of unjustly placing a patient in a straightjacket. Keeping a patient in the hospital until he or she can pay the bills is an example of false imprisonment. When a patient is oriented, competent, and not legally committed, the staff should avoid detaining the patient unless detention is authorized by an explicit hospital policy or by the hospital administrators. It is rare that a hospital would be justified in authorizing detention of such a patient.

e. **Invasion of Privacy**.

(1) Overview. Invasion of privacy involves interference with the right of a person "to be let alone." The right to privacy encompasses the right to be free from unwarranted intrusion into one's home. It includes the right to live one's life without having one's name, picture, or private affairs made public against one's will. It also protects against public disclosure of private factors and false publicity.

(2) Unauthorized release of information. The unauthorized release of information concerning a patient can result in a claim for invasion of privacy. It is best to follow institutional policies concerning confidentiality because some courts will impose liability for failure to follow institutional rules. Not all releases of information, however, violate the right to privacy.

intentional tort: a wrongful act that arises from the intent (not necessarily hostile) to bring about a result that will invade the interests of another in a legally unsanctioned way.

assault: a threatening approach that puts a person in fear of battery, unauthorized touching.

battery: intentional touch of another person without authorization.

defamation: injury to another person's reputation, either spoken (slander) or in writing (libel).

false Imprisonment: unlawful restraint or detention of a person.

Invasion of privacy: interference with the right of a person "to be let alone."

f. **Infliction of Mental Stress**. In a health care setting, it should be relatively easy to avoid this tort by treating a patient and his or her family in a civilized manner. Generally, it is thoughtless and outrageous behavior that falls into this category. (See below).

BABY PRESENTED IN A JAR OF FORMALDEHYDE

In Johnson vs Woman's Hospital (Tenn., 1975), the court ruled in favor of the plaintiff, Mrs. Johnson, who had given birth to a baby who died in the hospital. When Mrs. Johnson asked for her baby, a health care provider presented it in a jar of formaldehyde. This cruel behavior was deemed to be an intentional infliction of mental stress on the patient.

NOTICES FOR PERIODIC CHECKUPS SENT TO THE FAMILY OF A DECEASED PATIENT

In *McCormick vs Haley* (Ohio, 1973), a physician being sued for malpractice in the death of a patient sent notices to the family, reminders that the decreased woman was due for her periodic checkups. The last two notices were judged to be intentionally tortuous acts.

Section II: NEGLIGENCE

4-4. NEGLIGENT TORTS

a. Negligence is the most common basis for liability of health care professionals and hospitals.

b. Everyone makes negligent (careless) errors at sometime or another, which do not necessarily result in injury. If injury through actionable negligence is proven, you are liable, that is, legally responsible, and you can be sued for damages in a malpractice suit.

negligence: conduct which fails below a standard established by the law for the protection of others against unreasonable risk of harm; failure to exercise such care as would be expected of a reasonable person.

liable: legally responsible.

malpractice: professional negligence; failure to render proper services through reprehensible ignorance, negligence, or criminal intent, especially with resultant injury or loss.

4-5. THE FOUR ELEMENTS OF LIABILITY FOR ACTIONABLE NEGLIGENCE

As stated earlier, negligence is conduct that falls below a standard established by the law for the protection of others against unreasonable risk of harm. The four elements of liability for actionable negligence that must be established are: duty owed (the existence of a professional relationship), breach of duty (deviation from what should have been done), injury, and proximate cause or causation (a direct causal relationship between breach of duty and injury).

4-6. DUTY OWED, THE FIRST ELEMENT OF LIABILITY FOR ACTIONABLE NEGLIGENCE

Duty owed by a health care provider is conformance to a certain standard of conduct. This standard may be established by statute or, as with health care professionals, by professionals themselves. Standards for the code of ethics, adopted by the American Society of Radiologic Technologists and the American Registry of Radiologic Technologists (ARRT), were developed by the ARRT. Standards for radiologists were developed by the American College of Radiology.

4-7. BREACH OF DUTY, THE SECOND ELEMENT OF LIABILITY FOR ACTIONABLE NEGLIGENCE

a. **Scope of Duty (Standard of Care).** Once duty has been established, the scope of duty owed or the standard of care must be determined. The standard of care for hospitals is usually the degree of reasonable care that the patient's known or apparent condition would require. This is known as the "reasonable person" standard.

(1) In some states, reasonable care extends to conditions that the hospital should have discovered through the exercise of reasonable care. Generally, the standard for individual health care professionals is what a reasonably prudent health care professional engaged in a similar practice would have done under similar conditions. This is established through expert testimony and common sense. For example, a "reasonable person" would protect a disoriented patient from falling out of bed.

(2) Standards such as licensure regulations, accreditation standards, and institutional rules should be published/posted.

breach of duty: failure to provide a specific duty that is owed to the patient.

reasonable person standard of duty: a measurement of the actor's conduct against what a reasonably prudent person would have done under the same or a similar circumstance.

b. **Deviation From the Standard**. Once the scope of duty or the standard of care has been established, it must be shown that there was breach of duty, a deviation from the standard, or failure to do something that should have been done. The test of breach of duty relies on the reasonable person doctrine, which states that you have committed breach of duty when you have failed to do what a reasonably prudent professional would have done in the same or a similar situation. If, for example, you do an excretory urogram (XU), it is not your fault if the patient has an allergic reaction. But, you are at fault if you fail to have the emergency cart, with medications for allergic reactions, handy and in readiness.

RADIATION INJURY--DUTY OWED/BREACH OF DUTY

In *Synoff v. Midway Hospital* (Minn., 1970), the patient was burned because the x-ray technologist (radiographer) improperly aligned the machine for which he was responsible. The guide light came in contact with the anesthetized patient's skin, causing a burn. The radiologist, who was present, was not liable because alignment of the machine is within the scope of the radiographer's work and does not require a physician's supervision. As a result, the hospital was found liable for the radiographer's misalignment of the machine.

BREACH OF DUTY OF A REASONABLY PRUDENT PERSON

In *Albrition v. Bossler City Hospital Commission* (Calif., 1972), a patient, hospitalized for abdominal pain from a ruptured appendix was brought to the x-ray table on a stretcher. The radiographer did not notice that the x-ray requisition form did not include the required brief history or that the patient was heavily sedated. He raised the label to the vertical position without placing straps or supports on the patient, causing the patient to break an ankle. The hospital was held liable because an x-ray technologist has a duty to strap the sedated patient.

4-8. INJURY, THE THIRD ELEMENT OF LIABILITY FOR ACTIONABLE NEGLIGENCE

a. **Actual Loss or Damage.** Injury is the third element of actionable negligence that must be proven. The claimant must have suffered some kind of actual loss or damage. Injury may be physical, financial, emotional, or some other invasion of the plaintiff's rights and privileges, such as invasion of privacy. The defendant may be negligent and still not incur liability if no injury results to the plaintiff.

b. **Emotional Injury**. Good lawyers will try to convince juries of emotional trauma, although it is hard to measure. Most courts will not allow suits based solely on negligently inflicted emotional injuries. Usually, negligently inflicted emotional injuries are compensated only when they accompany physical injuries. Intentional infliction of emotional injury is compensated without proof of physical injury.

injury: a physical, financial, or emotional act, or some other invasion of the plaintiff's rights and privileges.

4-9. PROXIMATE CAUSE (CAUSATION), THE FOURTH ELEMENT OF LIABILITY FOR ACTIONABLE NEGLIGENCE

a. The fourth element of actionable negligence is proximate cause or causation. Whatever happened must be proven to be the immediate or the proximate cause of injury. In other words, it must be shown that it was, in fact, breach of duty that caused injury.

proximate cause (causation): the process of establishing the causal link between breach of duty and injury.

b. Causation is the most difficult element to prove. For example, a treatment may be negligently delayed (breach of duty) and the patient may die (injury), but it still must be proven that the plaintiff, in all likelihood, would have lived had the treatment been given sooner.

4-10. THE "FIFTH ELEMENT" OF LIABILITY FOR ACTIONABLE NEGLIGENCE

There is an additional element that is not discussed from a legal standpoint, but that has great bearing on whether or not a claim is filled. This "fifth element" involves the caring component of health care. There has to be someone willing to make a claim. Health care professionals who maintain a good relationship with their patients before and after incidents are less likely to be sued. If you suspect that an incident may have occurred, contact the responsible risk management official, so that steps can be taken to minimize the chances of a claim. Health care professionals, who maintain good relations with their patient, before and after an incident, are less likely to be sued.

TIME LAG MAKES IT IMPOSSIBLE TO PROVE CAUSATION

In *Lenger v. Physician's General Hospital* (Tex., 1970), the time lag between breach of duty and injury made it impossible to prove causation. After colon surgery, the patient was mistakenly given solid food by the nurse (duty owed/breach of duty). Eight days later, the ends of the sutured colon came apart (injury). Because time had elapsed, causation could not be proven.

NONACTIONABLE NEGLIGENCE

In *Salinetro v. Nystrom* (Fla., 1977), the patient's own ignorance of her condition made it impossible to prove causation. A woman received abdominal x-rays after an auto accident, without being asked if she were pregnant. Soon thereafter, she learned that she was pregnant and had an abortion on her obstetrician's recommendation. She sued the radiologist. He was found negligent for not asking if she was pregnant, but not liable because it was not his negligence that caused injury. Had he asked if she were pregnant, she still would have said, "No." Only if she had known about the pregnancy, and had stated thus when the x-rays were taken, could causation have been proven.

CAUSATION SHOWN

In *Schnebly v. Baker* (Iowa, 1974), causation was established. A baby, born with an Rh incompatibility, was erroneously diagnosed as having a safe bilirubin level. This inaccurate test result was due to the use of an outdated reagent for testing bilirubin levels. The pathologists and the hospital were liable because an accurate test result would have led to timely therapy that probably would have prevented the brain damage.

Continue with Exercises

EXERCISES, LESSON 4

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response(s) that best answer(s) the question or best completes the incomplete statement or by writing the answer in the space provided.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. Sean Poe takes his neighbor, Kim Pirelli, to court because her dog is keeping him awake at night. This is an example of:

   a. A criminal wrongdoing.

   b. A tort.

   c. Breach of contract.

   d. A violation of public policy.

2. A *willful* act involving another person's rights is a (an):

   a. Compensatory act.

   b. Violation of the Constitution.

   c. Criminal tort.

   d. Intentional tort.

3. Obtaining *written* permission to handle the patient for x-ray positioning would be the surest way to avoid being sued for:

   a. Assault and/or battery.

   b. Slander.

   c. Negligence.

   d. False imprisonment.

4. Intentional torts include assault and battery, defamation, false imprisonment, infliction of emotional stress, and:

   a. Negligence.

   b. Malpractice.

   c. Invasion of privacy.

   d. Breach of contract.

5. Approaching a patient with a large needle could be construed as _____ if the health care provider had not psychologically prepared the patient for it.

   a. Battery.

   b. False imprisonment.

   c. A no-fault tort.

   d. Assault.

6. Jabbing the patient with a needle when he or she has not indicated a willingness to receive it could be viewed as:

   a. Assault.

   b. Battery.

   c. False imprisonment.

   d. Negligence.

7. Inaccurate information is inappropriately released to the press that a celebrity is under treatment for AIDS at a local hospital. In fact, she is having her teeth soldered shut to induce a rapid weight loss. The celebrity can sue the hospital for:

   a. Trespass.

   b. Breach of contract.

   c. Defamation.

   d. False imprisonment.

8. A 20-year-old girl goes to San Antonio for the annual Fiesta. Upon arrival, she is hospitalized for a rash on her leg and flu-like symptoms. Several days of observation and testing result in the diagnosis of blood poisoning. The hospital recommends that she remain for further surveillance. She wants to be released, so that she can enjoy the week's festivities. She is competent and understands the risks involved, which she considers to be minor. The attending physician, who maintains that the risks are considerable, locks her in her room. She can file a suit for:

   a. False imprisonment.

   b. Slander.

   c. Emotional distress.

   d. Failure to keep a verbal promise.

9. An individual telephones the hospital inquiring if Mrs. Brandt had given birth and been discharged. The most prudent thing to do would be to avoid releasing this information, if the patient has requested nondisclosure, to avoid charges of:

   a. Negligence.

   b. Malpractice.

   c. Defamation.

   d. Invasion of privacy.

10. Tort liability is almost always based on:

    a. Fault.

    b. Proximity.

    c. Coincidence.

    d. Breach of practice.

11. Which of the following is applicable to intentional torts?

    a. The intent always involves a desire to harm someone.

    b. Intentional torts are the most common basis for liability in a hospital setting.

    c. The intent involved is not necessarily hostile.

    d. Fault is not involved.

12. The most common basis for liability for health care professionals and hospitals is:

    a. Failure to keep a verbal promise.

    b. Negligence.

    c. A breach of agreement.

    d. Criminal wrongdoing.

13. A hospital is found liable for injuries due to failure to properly segregate sterile and non-sterile needles. This means that:

    a. Harm was intentionally inflicted.

    b. The responsible health care providers will be fired.

    c. The hospital is legally responsible and is likely to pay damages.

    d. Injury may not necessary be due to careless behavior.

14. The four elements of liability for actionable negligence that must be proven are: duty owed, breach of duty, _____, and causation.

    a. Contractual obligations.

    b. Injury.

    c. Criminal intent.

    d. Proximate cause.

15. A radiologist is being sued for negligence. The plaintiff's lawyer will try to establish duty owed to the patient. In this case, the standard probably will have been set up by the:

    a. American Medical Association.

    b. American Bar Association.

    c. State legislature.

    d. American College of Radiology.

16. The test of breach of duty relies on:

    a. Contract law.

    b. Local policy.

    c. The "reasonable person" standard.

    d. Past state and Federal legislative enactments.

17. Injury can be physical, _____, emotional, or an invasion of the plaintiff's rights and privileges.

    a. Financial.

    b. Spiritual.

    c. Psychological.

    d. Contractual.

18. The most widely accepted basis for the negligent infliction of emotional injury is when:

    a. There is no physical injury.

    b. The plaintiff witnesses injury.

    c. Emotional injury is accompanied by a physical injury.

19 Most courts will NOT suits based solely on a negligently inflicted:

    a. Physical injury.

    b. Emotional injury.

    c. Financial injury.

    d. Loss of a right.

20. The element of liability for actionable negligence that is the most difficult to prove is:

    a. Duty.

    b. Breach of duty.

    c. Injury.

    d. Causation.

21. A female accident victim sues the radiologist for failing to ask if she were pregnant before taking x-rays. She later learns that she was pregnant at the time of the x-raying and has an abortion because of the radiation exposure suffered by the fetus. The case is dismissed because she did not know she was pregnant when she consented to the x-rays. (Had she been asked the question, "Are you pregnant?"? She still would have answered "No." Thus, the x-rays would have been taken anyway, even if the question had been duly asked). Which element could **NOT** be proven in this case?

    a. Duty owned.

    b. Breach of duty.

    c. Injury.

    d. Causation.

Check Your Answers on Next Page

SOLUTION TO EXERCISES, LESSON 4

1. b (para 4-2a)
2. d (para 4-3a)
3. a (para 4-3b(1))
4. c (paras 4-3a, e)
5. d (para 4-3b(1))
6. b (para 4-3b(2))
7. c (para 4-3c)
8. a (para 4-3d)
9. d (para 4-3e)
10. a (para 4-2b)
11. c (paras 4-2b, 4-3a)
12. b (para 4-4)
13. c (paras 4-4a, 4-7a)
14. b (para 4-5)
15. d (para 4-6)
16. a (para 4-8a)
17. a (para 4-8a)
18. c (para 4-8b)
19. b (para 4-8b)
20. d (para 4-9)
21. d (para 4-9a, b)

NOTES:

1. Jesse Birnbaum, “Crybabies: Eternal Victims,” Time Magazine, August 12, 1991, p 16.

2. Ibid.

3. Ibid., p 19.

4. Ibid.

5. Ibid.

End of Lesson 4

LESSON ASSIGNMENT

LESSON 5	Legal Doctrines That Affect Health Care.
LESSON ASSIGNMENT	Paragraphs 5-1 through 5-7
LESSON OBJECTIVES	After completing this lesson, you should be able to:

5-1. Identify the conditions required for the application of the legal doctrines of:

- *Res ipsa loquitur*.
- *Respondeat superior*.

5-2. Identify the Feres doctrine as it relates to the Federal Tort Claims Act.

SUGGESTION After completing the assignment, complete the exercises of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 5

Section I. *RES IPSA LOQUITUR* AND *RESPONDEAT SUPERIOR*

5-1. NO-FAULT LIABILITY AND THE DOCTRINE OF *RES IPSA LOQUITUR*

a. ***Res Ipsa Loquitur* Doctrine.** *Res ipsa loquitur* literally means not having to prove all four elements of liability for actionable negligence. As stated earlier, tort liability is almost always based on fault. But there are some cases in which liability is assessed regardless of fault and without having to prove the four elements of actionable negligence. Such cases are decided based on the legal doctrine of *res ipsa loquitur,* Latin for “the thing speaks for itself." This legal doctrine (the principle established through past court decisions or common law) allows a major exception to the requirement of proving all four elements of actionable negligence.

> ***Res Ipsa loquitur:*** the legal doctrine in which all four elements of actionable negligence need not be proven, literal meaning: "the thing speaks for itself."

b. **Origins of *Res Ipsa Loquitur.*** This doctrine was established in England during the 19th century in response to a case in which a barrel flying out of an upper story window smashed into a pedestrian. When the pedestrian tried to sue the owner of the building, the owner hid behind the fact that the plaintiff could not prove all four elements of liability for actionable negligence. Naturally, the plaintiff could not find out exactly what had gone wrong in the upper story room, that is, what the breach of duty was. Thus, it looked like the case would be lost. The court ruled, however, that the owner could not take advantage of the prevailing doctrine to escape liability when someone had clearly done something wrong. Consequently, the court developed the *res ipsa loquitur* doctrine.

c. **Essential Conditions for *Res Ipsa Loquitur.*** Five conditions must be met in order to invoke this doctrine (figure 5-1.) Even after the five conditions for *res ipsa loquitur* are met, finding for the plaintiff is not automatic. There is merely an inference that the defendant was negligent. (The plaintiff proves injury and causation; duty and breach thereof are inferred.) The defendant may try to document why injury was not the result of negligence.

d. **Applicable Cases**. Courts have often applied *res Ipsa loquitur* to two types of medical malpractice cases: sponges and other foreign objects unintentionally left in the body and injuries to parts of the body distant from the site of treatment, such as injury to an arm during eye surgery.

CONDITIONS FOR *RES IPSA LOQUITUR*

1. The accident ordinarily could not have occurred in the absence of negligence.
2. The instrument causing the injury is apparently in the exclusive control of the defendant.
3. The person suing did not contribute to the difficulties.
4. Evidence of the true cause is inaccessible to the person suing.
5. An injury has occurred.

Figure 5-1. Five conditions for *res ipsa laquitur*.

5-2. WHO IS LIABLE?

There are three types of liability: personal liability, liability for employees and agents, and institutional liability.

a. **Personal Liability**. Individual staff members are personnel liable for the consequences of their own acts. This liability is nearly always based on the principle of fault. To be liable, the person must have done something wrong or must have failed to do something that should have been done.

b. **Liability for Employees and Agents**. Employers can be liable for the *consequence of job-related acts of their employees or agents*, even if the employer is not at fault personally.

c. **Institutional Liability**. *Institutions* can also be liable for the consequences of the breach of duty owed directly to the patient and others, such as the maintenance of equipment and the selection and supervision of employees and medical staff. *Usually in liability cases, both the hospital and the health professional* (physician, radiologist, and/or nurse) are *sued*.

5-3. RESPONDEAT SUPERIOR

a. **Employer Liability for Employee Negligence**. *"Respondeat superior"* literally means, "let the master answer." This doctrine is the legal basis for making employers liable for the torts of their employees committed within the scope of their duties.

> ***Respondeat superior***: the legal doctrine that holds the employer liable for negligent torts committed by the employee within the scope of the employee's duties or employment. Literal meaning is "let the master answer." (The employer is not generally liable for the *intentional* torts of its employees.)

b. **Defining the Term "Employer."** The superior is not the employer. Since the supervisor is an employee, *respondeat superior* does not impose liability on the superior. Supervisors are liable only for the consequences of their own acts or omissions. Of course, the employer can also be liable for those acts or omissions under *respondeat superior*. The employer is the hospital (the body that hires, trains, and assigns the employee).

c. **Essential Conditions**. Can the *respondeat superior* doctrine be applied to the situation described on the next page, "The Case of the Incorrectly Labeled X-rays?" The employer (the hospital) can be held liable if the following conditions are met: there was employee negligence and the employee was acting within the scope of his or her employment.

(1) Employee negligence. It must be shown that the employee was negligent. In this case, the radiographer mislabeled for x-ray film.

(2) The scope of employment. The employee has to have been acting within the scope of his or her job (to include any actions to further the employer's business or incidental to performing daily work). This condition states that the employee has to have been acting within the scope of employment. In this case, it was a full-time x-ray technologist taking the x-ray. (The employee could also have been a part-time employee hired to fill in for a full-time employee.)

d. **Who Gets Sued and Who Pays Damages?** *Respondeat superior* gives the injured party the option of suing either the employee or the employer, or both. In the last example, the hospital, the attending physician, and the radiographer were sued. If the employee is individually sued and found liable, the employee must pay damages (i.e., his or her malpractice insurance pays). If, as usually occurs, the employee is not individually sued, then the employer's insurance must pay. In other fields, however, the employer may well take damages out of the employee's wages. For example, a mechanic messes up your car. His boss concedes that you are owed $800 in damages. The boss may turn around and take money out of the employee's paycheck.

IN THE CASE OF THE INCORRECTLY LABELED X-RAYS, THE EMPLOYER IS RESPONSIBLE UNDER *RESPONDEAT SUPERIOR*

A 6-month-old infant is admitted to the hospital with a bad cold. The attending physician, listening with her stethoscope, detects heave congestion in the left lung. Based on the preliminary exam, the attending physician orders chest x-rays at a *vertical* chest x-ray unit. (The radiographer is use to seeing adult patients learning with the chest against the x-ray film cassettes, so that the right lung is on the right side of the film. Infants, on the other hand, because of their size, are placed in the *supine* position, lying face up on the x-ray film cassettes. This means that for an infant, the right lung would be on the left side of the film).

The x-ray technologist, forgetting that the baby's body is reversed from the customary (adult) orientation, inadvertently marks an "R" on the upper right-hand side of the film which is, in fact, the infant's left lung. Based on the inaccurately labeled x-rays, inappropriate treatment is provided and the baby dies. The parents sue the hospital, the attending physician, and the radiologist. Under *respondeat superior*, the employer (the hospital) is liable for the acts of its employees, that is, the x-ray technologist. The physician could be liable for negligence in not recognizing the mistake.

FURTHERING ONE'S OWN BUSINESS INTERESTS

An Army physician retires to go into private practice in Nebraska. He asks a sergeant, an x-ray technologist who is also retiring, to join his practice.

In the wide-open spaces of Nebraska, the physician finds a huge market for portable ultrasounds at nursing homes. The physician buys a van and ultrasound equipment, and has the ex-sergeant make the rounds of the nursing homes to take the x-rays.

If the sergeants were found to be negligent, it is most likely that the employer (the physician) could be sued under *respondeat superior*. The ex-sergeant, employed by the physician and using the physician's van and equipment, has acted to further the interests of his employer.

But, it the ex-sergeant bought a van and equipment (licensed in the physician's name) and contracted a radiologist to read the films, the ex-sergeant, as the owner furthering his own interests, would more likely be sued than the physician.

In both cases, the claimant could opt to sue either the employer or the employee, but the employer would be the one more likely to be sued.

Initially, *respondeat superior* did not apply to the US Government. The Government could not be held accountable for the negligent acts of its employees.

Section II. FEDERAL TORT CLAIMS ACT

5-4. GOVERNMENT IMMUNITY FROM TORTIOUS ACTS

a. **"The King Can Do No Wrong."** Initially, *respondeat superior* did not apply to the US Government in its capacity as employer. Thus, the Government could not be held accountable for the negligent acts of its employees. This immunity of Government for the official acts of its officers, agents, and employees was a legacy of English common law of sovereign immunity: "the King can do no wrong." The Government could not be sued because no officer or employee of the Government had been authorized to do unlawful acts. This meant that citizens suffering injuries had only two equally unproductive avenues of redress. They could sue generally underpaid Government employees directly, rather than suing the Government. Or, they could petition Congress to grant a private Act on their behalf.

b. **Partial Consent for the Government to be Sued**. In modern times, the fiction that the sovereign can do no wrong was abolished, to some extent, with the passage of the Federal Tort Claims Act of 1946, giving partial consent for the Federal Government to be sued for negligent torts of its employees while they are acting within the scope of their employment. Under this Act, the US Government may be liable under local law for negligent torts committed by Federal employees within the scope of their employment, in the same way a private individual could be held liable. The Federal Tort Claims Act can be considered another application of the *respondeat superior* doctrine since it makes an employer, in this case the US Government, liable for certain negligent acts of its employees.

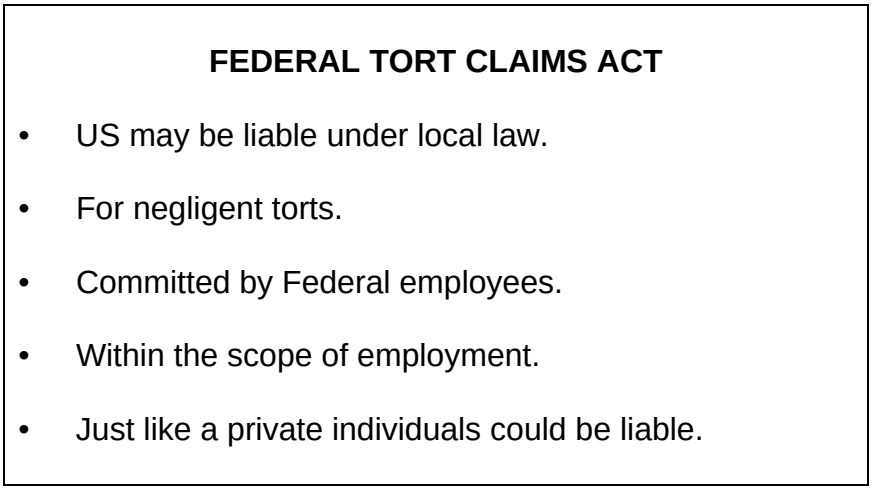
FEDERAL TORT CLAIMS ACT
• US may be liable under local law.
• For negligent torts.
• Committed by Federal employees.
• Within the scope of employment.
• Just like a private individuals could be liable.

Figure 5-2. Federal Tort Claims Act.

c. **Conditions for Filing Suit Against the Government.**

(1) Negligent act. A negligent act was committed by a Government employee.

(2) Scope of employment. The employee was acting within the scope of his or her employment.

(3) Injury. The negligent act resulted in injury.

(4) Causation. There was a causal link between the negligent act and injury.

ACTING WITHIN THE SCOPE OF EMPLOYMENT

A soldier, driving a military truck, swerves across the centerline because he fell asleep at the wheel or wasn't looking. His negligence causes an injury to the civilian whose car he crashes into. In this situation, a negligent act was committed within the employee's scope of employment, and it caused an injury. Therefore, the Government could be liable for the negligent act of the soldier.

d. **Exceptions.** Intentional torts, claims arising from combat activities, and claims arising in foreign countries are not covered.

e. **Proper Claimants.** The public at large, military family members, and retirees from the US military service can file suit under the Federal Tort Claims Act. Suit can be filed for injury to a soldier or a retiree that is *not* incident to service and for any injury to military family members.

5-5. FERES DOCTRINE: SERVICE-CONNECTED INJURIES NOT INCLUDED

a. **Limitations on the Federal Tort Claims Act.** The Feres doctrine restricts the applicability of the Federal Tort Claims Act. It states: "The Government is not liable for injuries under the Federal Tort Claims Act for injuries to service members where the injuries arise out of or are in the course of activity incident to service." The Feres doctrine was developed in response to service members using the Federal Tort Claims Act to file suit against the Government. Congress maintains that military personnel are already covered for the peculiar dangers to which they are exposed through the elaborate provisions for allowances, retirement benefits, and medical and hospital treatment, which are always available.

b. **Incident to Service.** The Government is not liable for injuries that are incident to service. Any injury is considered "incident to service" if sustained while performing official duties, including permanent change of station (PCS) or temporary duty (TDY). It is also likely to be classified as "incident to service" if it was incurred at a service member's home installation, in a military aircraft, or in a military medical/dental facility.

INJURIES INCIDENT TO SERVICE ARE THOSE OCCURRING:

- While performing official duties (also PCS and TDY).
- On a service member's home installation.
- In a military aircraft.
- In a military medical/dental facility.

Figure 5-3. Incident to service injuries.

SERVICE MEMBERS ALREADY COVERED FOR INJURIES INCIDENT TO SERVICE

In Jefferson v. United States (US C.A. 4th) an enlisted solider brought suit against the US for damage caused by an Army surgeon who negligently left a towel in his abdomen following a gallbladder operation. The civil courts dismissed the case because they deemed it inappropriate to pass upon the propriety of military decisions and actions.

In Perucki vs United States (Pa., 1948), a veteran with combat injuries reported to the Veteran's Administration for an exam to assess a reduction in his rate of liability. While applying lighted matches to the soldier's legs to test reflexes, the physician burned both of the soldier's legs, causing injuries and disability. The courts dismissed the veteran's suit, stating that the burns would not have been sustained were it not for the original injuries received in combat.

5-6. NONSERVICE-CONNECTED INJURIES COVERED

a. **Nonservice Connected.** Claims by veterans for conditions that are non-service connected *(not* incident to service) are covered by the Federal Tort Claims Act.

b. **Not Incident to Service**. Members of the armed forces can recover if injury is not incident to service. In *Brooks vs. United States* (US 1949), claims were made against the US Government for injuries to one serviceman and death to another occurring while the soldiers were on furlough, and not in any way incident to their military service. At the time of the accident, the two soldiers were riding in their own automobile while on leave and were struck by a US Army truck driven by a civilian employee of the Army. The court honored this suit. Many times, however, it is not always clear whether or not a military member was injured incident to service. However, anytime a service member is injured on a military installation, he or she is injured incident to service. When a service member is on active duty and injured incident to service, the Government cannot be sued for negligence of its employees.

NONSERVICE-CONNECTED INJURY COVERED UNDER THE FEDERAL TORT CLAIMS ACT

In *Santana vs. United States* (US C.A., 1st) (1950), an honorably discharged soldier died as a result of treatment at a Veteran's Administration hospital. Since he was not in the service at the time the negligence occurred (he had returned to private life as a discharged veteran), the negligence was nonservice connected. Acceptance of his claim under the Federal Tort Claims Act did not involve "subversion of military discipline."

5-7. DISPUTE RESOLUTION MECHANISMS

a. **Screening Panels**. A number of states have enacted laws requiring all malpractice claims to be screened by a panel before a suit can be filed. The panels are aimed at promoting a settlement of meritorious claims and an abandonment of frivolous ones. A few courts have held screening panels to be an unconstitutional infringement of rights of access to courts. For the most part, however, courts have upheld the required use of screening panels since the plaintiffs still have the right to sue after the screening process is completed.

b. **Arbitration**. Several states have authorized binding agreements to arbitrate future malpractice disputes. When there is a valid agreement to arbitrate, the dispute is submitted to an arbitrator who decides whether there should be any payment, and if so, how much. Many agreements provide for an arbitration panel rather than a single arbitrator. Generally, courts can set aside arbitration decisions only for limited reasons, such as failure to follow proper procedures or bias of the arbitrator. A valid arbitrator decision has the same effect as a court judgment and can be enforced using the same mechanisms. Some health care providers and patients favor arbitration because it is *faster* and *far less costly than litigation*. It is a less formal process that avoids adverse publicity and the complex rules of litigation that promote an adversarial relationship. Others dislike arbitration, preferring disputes decided by a jury using procedures more familiar to attorneys. Some providers believe they have a better chance by a jury of avoiding any payment, while some patients believe that if they win, they will be awarded larger payment. In some states, like California, arbitration agreements have been enforced in many cases. In some states, the status of arbitration is unclear.

Continue with Exercises

EXERCISES, LESSON 5

INSTRUCTIONS: The following exercises are to be answered by marking the lettered response(s) that best answer(s) the question or best completes the incomplete statement or by writing the answer in the space provided. For a true/false item, indicate whether the statement is true or false.

After you have completed all the exercises, turn to "Solutions to Exercises" at the end of the lesson and check your answers.

1. The _____ doctrine eliminates the requirement to establish all four elements of actionable negligence.

   a. Reasonable person.

   b. *Res ipsa loquitur*.

   c. *Respondeat superior.*

   d. Double servant.

2. When the doctrine “the thing speak for itself” is applied, the claimant proves:

   a. All four elements of liability for actionable negligence.

   b. Injury and causation; duty and breach thereof are interred.

   c. Duty and breach of duty; injury and causation are inferred.

   d. Injury only.

3. Under *res ipsa loquitur*, it must be shown that the instrument causing the injury was:

   a. Defective.

   b. Used by the plaintiff.

   c. Carelessly manipulated by the plaintiff.

   d. In the exclusive control of the defendant.

4. To invoke the *res ipsa loquitur* doctrine, it must be shown that _____ did NOT contribute to the injury.

   a. The plaintiff.

   b. The defendant.

   c. Chance.

   d. Proximate cause.

5. In *res ipsa loquitur* cases, evidence of the true cause of the injury must be:

   a. Accessible to all.

   b. Accessible to the person suing.

   c. Inaccessible to the plaintiff.

6. In res ipsa loquitur cases, there must be:

   a. Emotional damage.

   b. An injury.

   c. Insurance.

   d. An eyewitness.

7. The res ipsa loquitur doctrine is frequently applied in two types of medical malpractice cases--foreign objects left unintentionally in the body and:

   a Mislabeled x-ray films.

   b. Injuries at the site of treatment.

   c. Bad results after an operation.

   d. Injuries to body parts far from the treatment site.

8. The “employer” in *respondeat superior* cases is defined as the:

    a. Supervisor.

    b. Trainer.

    c. Evaluator.

    d. Hospital (hiring/firing agency).

9. Under *respondeat superior*, the injured party can sue:

    a. The employee.

    b. The employer.

    c. Both, the employee and the employer

10. Under the Federal Tort Claims Act, the Government:

    a. Claims immunity from suit.

    b. Gives partial consent to be sued.

    c. Claims immunity from claims by service members.

    d. Gives partial consent for contract actions by service members.

11. A service member who is on post and acting within the scope of duty crashes the military truck that he is driving into the car of a civilian, causing the civilian injury. Who can be sued?

    a. The Government.

    b. The truck manufacturer.

    c. The civilian.

    d. The civilian’s insurance company.

12. A service member who is off duty falls asleep at the wheel, causing an auto accident in which a civilian is injured. Under the Federal Tort Claims Act, the Government *cannot* be sued because the soldier was:

    a. Probably intoxicated.

    b. Not intentionally negligent.

    c. Not acting within the scope of his or her employment.

13. The _____ doctrine restricts the applicability of the Federal Tort Claims Act, so that injuries incident to service are NOT included.

    a. *Res ipsa loquitur*.

    b. Feres.

    c. Borrowed servant.

    d. *Respondeat superior*.

14. Under the Federal Tort Claims Act, the Government can be sued:

    a. For a soldier's injuries incident to service.

    b. If a soldier receives inadequate training.

    c. If a soldier gets injured while being treated in a military medical/dental facility.

    d. For injury suffered by a dependent.

15. Under the Federal Tort Claims Act, an injured soldier would probably NOT sue for damages if injury occurred during PCS or TDY.

    a. True.

    b. False.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 5

1. b (para 5-1a)
2. b (para 5-1c)
3. d (para 5-1c: figure 5-1, condition 2)
4. a (para 5-1c: figure 5-1, condition 3)
5. c (para 5-1c: figure 5-1, condition 4)
6. b (para 5-1c: figure 5-1, condition 5)
7. d (para 5-1d)
8. d (para 5-3b)
9. c (para 5-3d)
10. b (para 5-4b)
11. a (para 5-4c(2); anecdote, “Acting Within the Scope of Employment”)
12. c (para 5-4c(1))
13. b (para 5-5a)
14. d (para 5-4e)
15. a. (para 5-5b)

End of Lesson 5

APPENDIX A

CODE OF ETHICS FOR X-RAY TECHNOLOGISTS

Principle 1. The Radiologic Technologist conducts himself/herself in a professional manner, responds to patient needs, and supports colleagues and associates in providing quality patient care.

Principle 2. The Radiologic Technologist acts to advance the principal objective of the profession--to provide services to humanity with full respect for the dignity of mankind.

Principle 3. The Radiologic Technologist delivers patient care and services unrestricted by the concerns of personal attributes or the nature of the disease or illness, and without discrimination regardless of sex, race, creed, religion, or socioeconomic status.

Principle 4. The Radiologic Technologist practices technology founded upon theoretical knowledge and concepts, utilizes equipment and accessories consistent with the purposes for which it has been designed, and employs procedures and techniques appropriately.

Principle 5. The Radiologic Technologist assesses situation; exercises care, discretion, and judgment; assumes responsibility for professional decisions; and acts in the best interest of the patient.

Principle 6. The Radiologic Technologist acts as an agent through observation and communication to obtain pertinent information from the physician to aid in the diagnosis and treatment management of the patient, and recognizes that interpretation and diagnosis are outside the scope of practice for the profession.

Principle 7. The Radiologic Technologist utilizes equipment and accessories, employs techniques and procedures, performs services in accordance with an accepted standard of practice, and demonstrates expertise in limiting the radiation exposure to the patient, self, and other members of the health care team.

Principle 8. The Radiologic Technologist practices ethical conduct appropriate to the profession and protects the patient's right to quality, radiological technology care.

A code of ethics serves as a guide by which professionals may evaluate their professional conduct as it relates to patients, colleagues, and other members of the allied professions and health care consumers. The code of ethics is not law, but it is intended to assist radiological technologists in maintaining a high level of ethical conduct.

End of Appendix A

APPENDIX B

A MODEL OF THE PATIENT'S BILL OF RIGHTS

1. The patient has a legal right to informed participation in all decisions involving his or her health care program.

2. We recognize the right of all potential patients to know what research and experimental protocols are being used in our facility and what alternatives are available in the community.

3. The patient has a legal right to privacy respecting the source of payment for treatment and care. The right includes access to the highest degree of care without regard to the source of payment for that treatment and care.

4. We recognize the right of a potential patient to complete and accurate information concerning medical care and procedures.

5. The patient has a legal right to prompt attention, especially in an emergency situation.

6. The patient has a legal right to a clear, concise explanation of all proposed procedures in layman's terms, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. He or she will not be subjected to any procedure without his or her voluntary, competent, and understanding consent. The specifics of such consent shall be set out in a written consent form signed by the patient.

7. The patient has a legal right to clear, complete, and accurate evaluation of his or her condition and prognosis without treatment before he or she is asked to consent to any test or procedure.

8. We recognize the right of the patient to know the identify and professional status of all those providing service. All personnel have been instructed to introduce themselves, state their status, and explain their role in the health care of the patient. Part of this right is the right to know the physician responsible for his/her care.

9. We recognize the right of any patient who does not speak English to have access to an interpreter.

10. The patient has a legal right to all the information contained in his or her medical record while in he health care facility and to examine the record upon request.

11. We recognize the right of a patient to discuss his or her condition with a consultant-specialist at his or her own request and his or her own expense.

12. The patient has a legal right not to have any test or procedure designed for educational purposes, rather than for his or her direct personal benefit, performed on him or her.

13. The patient has a legal right to refuse any particular drug, test procedure, or treatment.

14. The patient has a legal right to both personal and informational privacy with respect to: the hospital staff, other doctors, residents, interns and medical students, researchers, nurses, other hospital personnel, and other patients.

15. We recognize the patient's right of access to people outside the health care facility by means of visitors and telephone. Parents may stay with children and relatives with terminally ill patients 24 hours a day.

16. The patient has a legal right to leave the health care facility, regardless of physical condition or financial status, although he or she may be requested to sign a release stating that he or she is leaving against the medical judgment of his or her doctor or the hospital.

17. No patient may transfer to another facility unless: he or she has received a complete explanation of the desirability and need for the transfer, the other facility has accepted the patient for transfer, and the patient has agreed to transfer. If the patient does not agree to transfer, the patient has the right to a consultant's opinion on the desirability of transfer.

18. The patient has the right to be notified of discharge at least 1 day before it is accomplished, to demand a consultation by an expert on the desirability of discharge, and to have a person of the patient's choice notified.

19. The patient has the right, regardless of source of payment, to examine and receive an itemized and detailed explanation of his or her total bill.

20. The patient has the right to competent counseling to help him or her obtain financial assistance from public or private sources.

21. The patient has the right to a timely prior notice of the termination of his or her eligibility for reimbursement for the expense of his/her care by any third-party payer.

22. The patient has the right, at the termination of his or her stay, to a complete copy of the information in his or her medical record.

23. The patient has the right to have 24-hour-a-day access to a patient's rights advocate, who may act on behalf of the patient to assert or protect the rights set out in this document.

End of Appendix B

APPENDIX C

GLOSSARY

A

actionable negligence: negligence for which legal responsibility (liability) can be assessed (para 4-1a).

action (defendant): the party against whom damages are sought for injury in a tort suit (para 4-2a).

assault: a threatening approach that plus a person in fear or battery, unauthorized touching (para 4-3b(1)).

attitude: a grouping of beliefs around a specific object or situation; how one *feels* about something (para 2-2d).

B

battery: intentional touching of another person without authorization (para 4-3b(2)).

belief: the conviction that something is true (para 2-2c).

*** beneficence**: the concept that the role of the health care provider is to care for the patient, to do good (para 1-3g).

biomedical ethics: a philosophical study of what is right and wrong in the modern biological sciences, medicine, health care, and medical research (para 1-5a).

* **brain death**: the irreversible cessation of *circulatory* and *respiratory* functions or of *all* functions of the entire brain, including the brain stem (para 2-9d).

breach of duty: failure to provide a specific duty that is owed to the patient (para 4-7b).

***** Term occurring in MD0067, Health Care Ethics II.

C

claimant (plaintiff): the alleged injured party who seeks damages in a tort suit (para 4-2a).

clinical ethics: a type of ethics that involves identificatin, analysis, and resolution of moral problems encountered at the bedside (para 1-5a).

common law: a body of laws originating from Federal, state , and local court decisions (para 3-5a).

compensatory damages: payment designed to make the injured party "whole" to the extent that money can do so (para 4-2b).

* **competent (for consent purposes)**: having the mental capacity to understand information, deliberate according to values, weigh the consequences of one's own decisions, and communicate one's wishes; a legal determination (para 1-23b).

* **confidentiality**: the ethical responsibility of health care providers to maintain the secrets of their patients, communicated to them or learned through observation, examination, or conversation, and not to communicate same except to those with an official need to know (para 3-8).

* **consent**: the free (uncoerced) authorization of the patient to make his or her own decisions as to whether or not, and how to receive competent medical care (para 1-2).

D

damages: payment (compensation) for injury in a tort suit (para 4-2b).

decisions and rules: mandates and decisions from Federal and state administrative agencies, e.g., the Environmental Protection Agency (EPA), the Food and Drug Administration (FDA), the Internal Revenue Service (IRS) (para 3-4a).

defamation: injury to another person's reputation, either spoken (slander) or in writing (libel) (para 4-3c).

defendant: See "actor."

* **Do Not Resuscitate (DNR) order**: a written order to suspend an otherwise automatic initiation of cardiopulmonary resuscitation (CPR) (para 2-8a).

E

* **emancipated minor**: a minor who has assumed the life-style and responsibilities of
adult status and is not supported by either parent (para 1-26c).

* **ethical integrity of the health care profession**: the medical profession's right to act affirmatively to save lives without fear of civil liability (para 2-17).

ethics: a disciplined study of morality (what is right and wrong). It attempts to sort out the confusion created by the conflicting sources of morality (para 1-4).

* **express consent**: consent given by *direct* communication, either orally or in writing (para 1-7).

* **extension doctrine**: the doctrine that allows the physician the prerogative to extend care beyond the scope of express consent in an emergency (para 1-6d).

F

false imprisonment: unlawful restraint or detention of a person (para 4-3d).

G

H

Hawthorne effect: a temporary positive effect resulting from any changes in environment or conditions (para 1-1f),

I

* **Implied consent**: approval *inferred* from the patient's conduct; or voluntary submission with *apparent* knowledge of the nature of the procedure; or *presumed* consent in a life-threatening emergency (para 1-6).

* **incompetent (for consent purposes)**: lacking the mental capacity to make rational decisions or to conduct one's personal affairs; a legal determination (para 1-24).

* **Informed consent**: the free (*uncoerced*) authorization of procedure that given by a competent individual, having *sufficient information* (para 1-13).

Injury: a physical, financial or emotional act, or some other invasion of the plaintiff's rights and privileges (para 4-8a).

Instrumental value: a decision to choose one mode of conduct, e.g., honesty, cooperation, self-control, over another (para 2-2b).

Intentional tort: a wrongful act that arises from the intent (not necessarily hostile) to bring about a result that will invade the interests of another in a legally unsanctioned way (para 4-3a).

Invasion of privacy: interference with the right of a person "to be let alone" (para 4-3e(1)).

* **Irreversible terminal illness**: a progressive disease or illness known to terminate in death, and for which additional therapy offers no reasonable expectation of remission (para 2-28).

J

K

L

liable: legally responsible (para 4-4b).

* **life-sustaining treatment**: any medical procedure or intervention which serves only to *artificially* prolong the dying of a patient, diagnosed and certified by at least two physicians as afflicted with a terminal condition or as being in a persistent or chronic vegetative state (para 2-9b).

M

malpractice: professional negligence; failure to render proper services through reprehensible ignorance, negligence, or criminal intent, especially with resultant injury or loss (para 4-4b).

* **materiality (material risk) standard of disclosure**: the standard of disclosure whereby the physician's duty to disclosure information material to the decision is determined by the informational needs of a hypothetical *objective* "*reasonable patient*," not by professional practice (para 1-14c).

* **medical record**: a document that outlines patient evaluation, findings, diagnosis, and/or treatment (para 3-1).

* **mental capacity**: the ability to make decisions and weigh alternatives; a *clinical* determination made by the physician (para 1-24c).

morality: conformity to the rules of right conduct (para 1-4).

moral dilemma: a no-win situation in which the choice is between conflicting moral principles of equal importance (para 2-7).

N

negligence: conduct which falls below a standard established by the law for the protection of others against unreasonable risk of harm; failure to exercise such care as would be expected of a reasonable person (para 4-4a).

normative ethics: a type of ethics that formulates ethical theories and specifies behaviors that support ethical standards (para 1-5d).

O

P

* **paternalism**: a practice of treating people in an authoritarian manner, especially by taking care of their needs without giving them any responsibility for health care decisions (para 2-12d).

* **persistent vegetative state**: a chronic state of diminished consciousness resulting from severe generalized brain injury, in which there is no reasonable possibility of improvement to a cognitive (perceiving and knowing) state (para 2-8b).

placebo effect: a positive therapeutic effect resulting from an inert medication, preparation, or intervention given for its psychological influence, or as a control in an experiment (para 1-1f).

plaintiff: See “claimant.”

* **privacy**: the right “to be let alone,” to be free from unwarranted publicity, to live without having one’s name, picture, or private affairs made public or published against one’s will (para 3-6).

private law: a body of laws governing the relationship between private individuals and organizations (para 3-7b).

***privileged (confidential) communication**: communication between parties in a confidential relationship (physician - patient, lawyer - client, clergyman-layperson, husband - wife). The confidence is transmitted under circumstances implying it shall forever remain a secret (para 3-10a).

professional ethics: a set of standards of professional conduct set down in codes (para 1-5b).

professional code of ethics: a statement of role morality for a given profession, as expressed by members of that profession, rather than external bodies such as governmental agencies (para 1-5b).

*** professional practice standard of disclosure**: a standard of disclosure that requires the physician to disclose what any reasonable *health care provider* would communicate in the same or a similar circumstance (para 1-14b).

proximate cause (causation): the process of establishing the casual link between breach of duty and injury para 4-9).

public law: a body of laws governing the relationship between private individuals and government (or government agencies) in order to protect society as a whole (para 3-7c).

punitive damages: compensation set at a high level in order to punish the actor and serve as an example to deter others (para 4-2b).

Q

R

*** reasonable person (materiality) standard of disclosure**: See "materiality (material risk) standard of disclosure."

reasonable person standard of duty: a measurement of the actor's conduct against what a reasonably prudent person would have done under the same or a similar circumstance (para 4-7a).

***res ipsa loquitur**:* the legal doctrine in which all four elements of actionable negligence need to not proven; literal meaning: "the thing speaks for itself" (para 5-1a).

***respondeat superior**:* the legal doctrine that holds the employer liable for negligent torts committed by the employee within the scope of the employee's duties or employment. Literal meaning is "let the master answer." (The employer is not generally liable for the intentional torts of its employees) (para 5-3a).

S

statutory law: a body of written laws originating in Federal, state, and local legislatures (para 3-3a).

* **subjective test of the reasonable patient standard of disclosure**: the standard whereby the physician's duty to disclose information material to the decision is determined by the informational needs of the individual patient (para 1-14c(2)).

T

terminal value: a value based on a decision to choose one end-state of existence in favor of another, e.g., quality of life versus sanctity of life (para 2-2b).

* **therapeutic privilege**: the physician's prerogative to withhold information if he or she reasonably believes that the patient's mental or physical well-being would suffer as a result of learning the information. (Consent must still be obtained, usually from a relative) (para 1-18)).

tort: a civil wrongdoing or injury, other than contractual, which gives rise to an action for damages to compensate the injured party (paras 3-9c and 4-2a).

U

V

value: a goal or an ideal upon which we base decisions affecting our lives (para 1-1c).

End of Appendix C